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Vol. 15 No. 1
January, 1966

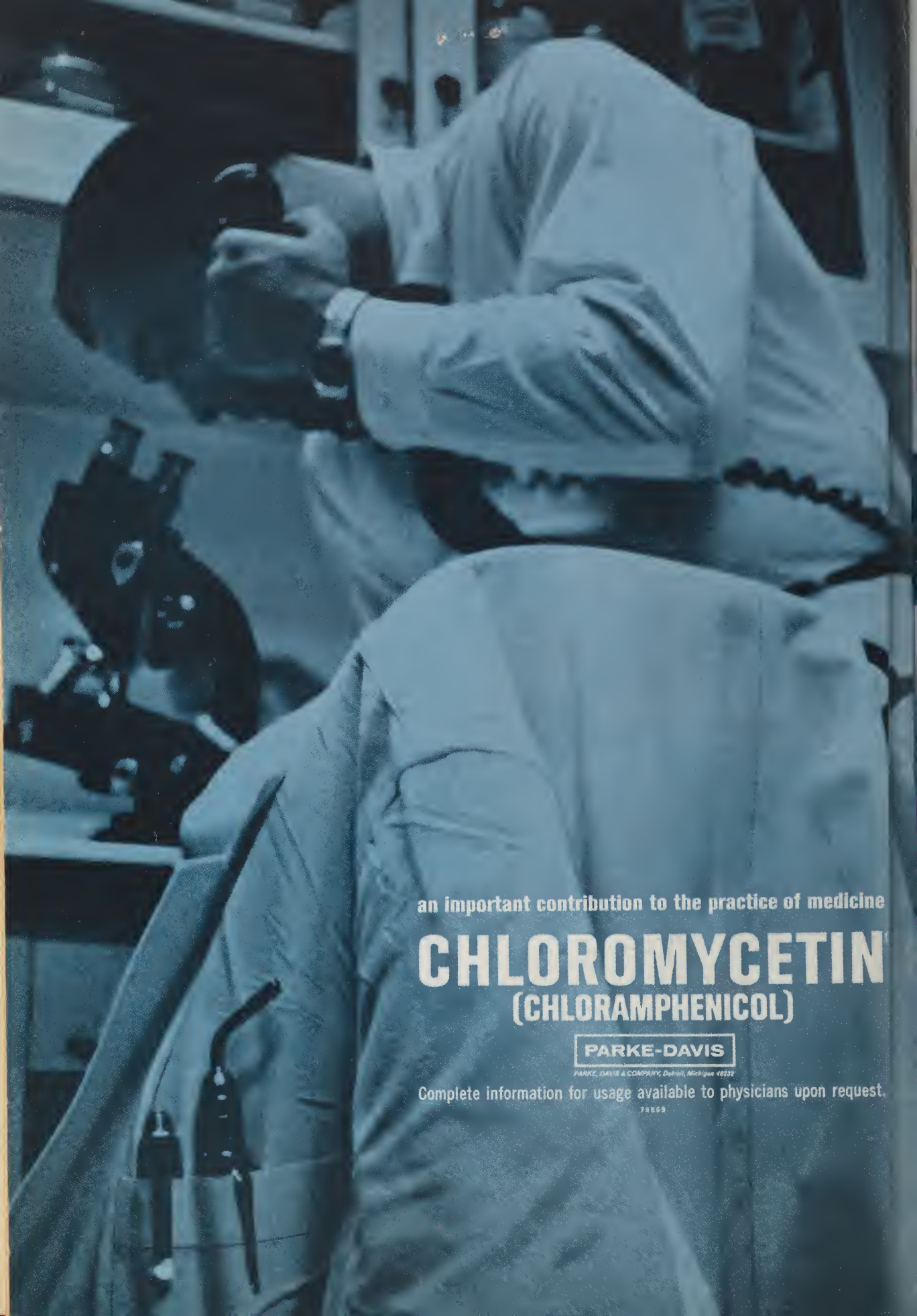
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STATE MEDICAL JOURNAL

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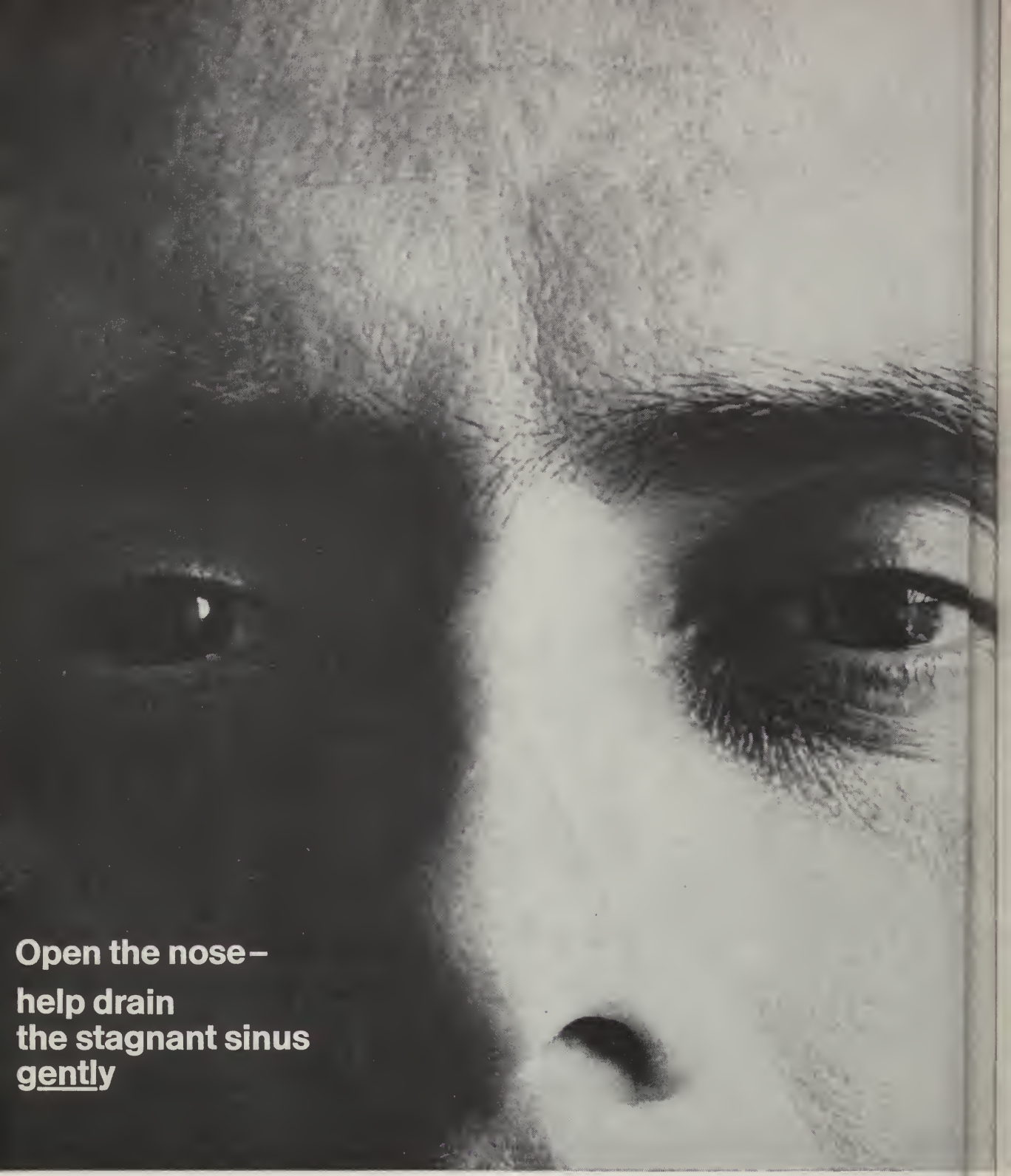
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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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*Proctor, D. F.: The Nose, Paranasal Sinuses and Ears in Childhood, Springfield, Ill., Charles Thomas, 1963, p. 34.

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Maryland
STATE MEDICAL JOURNAL

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Vol. 15, No. 1
January, 1966

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EDITORIAL

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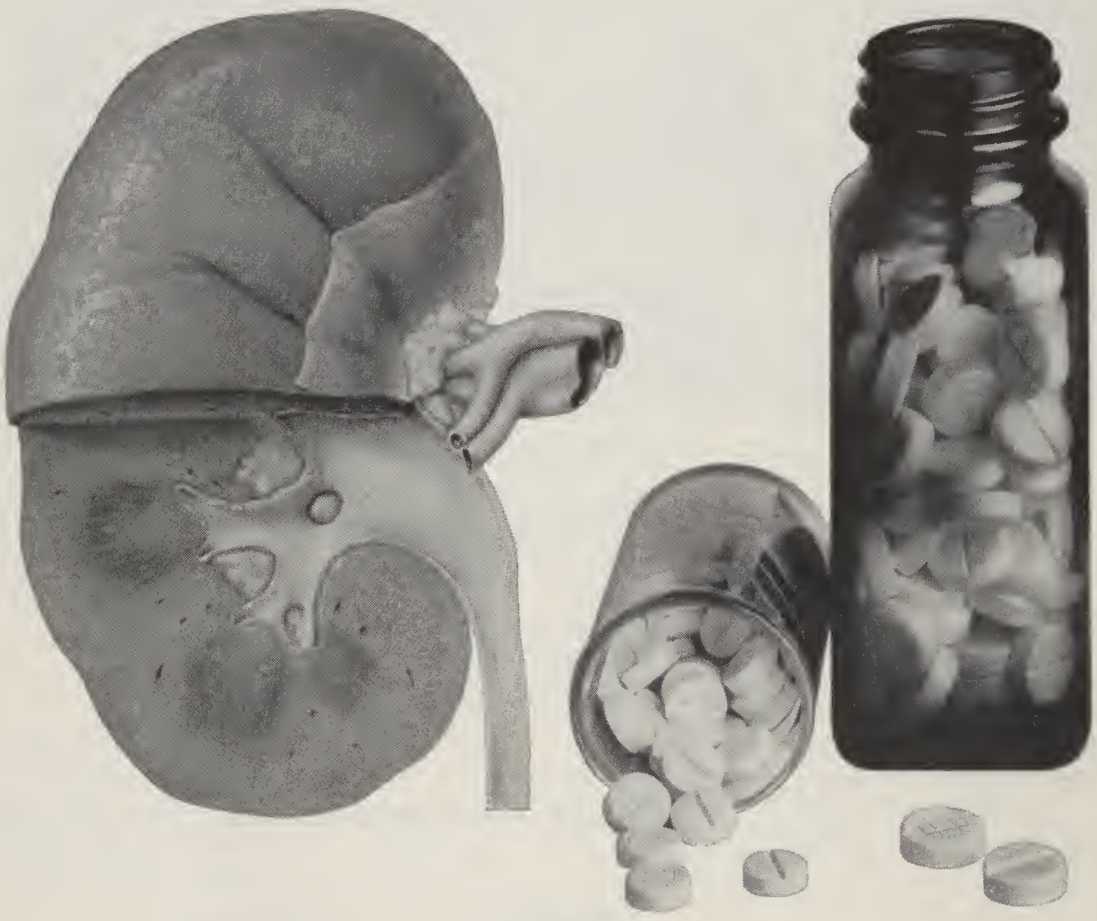
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Professional Business Management

The New Patient 127
Wilburn L. McClure, Jr.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

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Doctors take note...

MARK THESE IMPORTANT DATES ON YOUR CALENDAR

April 27-May 4, 1966—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland. April 27-28, Baltimore—April 29-May 4, Aboard ship and in Bermuda

MEDIC PROGRAMS

January 28—1-2 PM

From Frederick Memorial Hospital: "Some Unusual Presentations of Lymphoma," Ernest W. Smith, MD.

February 4—12:30-1:30 PM

From University Hospital: "Problems in the Diagnosis of Coronary Disease," Leonard Scherlis, MD.

February 9—8 PM

From Anne Arundel County Medical Society: "Lang Term Effects of Estrogen—Progestin Combinations," Alvin F. Goldfarb, MD.

February 11—12:30-1:30 PM

From The Johns Hopkins Hospital: "Arthritis," Lawrence E. Shulman, MD.

February 25—1-2 PM

From Frederick Memorial Hospital: "Iron Metabolism," Major Marcel Conrad.

You may hear these programs in the Faculty auditorium or at one of the participating hospitals.

MARYLAND DERMATOLOGICAL SOCIETY

January 26—7:30 PM—Velleggia's Restaurant, Baltimore

"Skin Diseases in Pakistan," Celeste Woodward, MD, University of Maryland School of Medicine.

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

February 1—7:30 PM—1211 Cathedral St., Baltimore

"Problems Facing Anesthesiology in America," Perry P. Volpitto, MD, Medical College of Georgia.

BALTIMORE CITY MEDICAL SOCIETY

February 4—8:30 PM—1211 Cathedral St., Baltimore

THE PHYSICIAN AND MEDICARE—REHABILITATION

"Resources," Aubrey D. Richardson, MD, medical director, Keswick Nursing Home.

"Physical and Occupational Therapy Techniques," Paul F. Richardson, MD, associate professor of physical medicine and rehabilitation and head, Division of Physical Medicine and Rehabilitation, University of Maryland School of Medicine.

"Problems in Cerebrovascular Strokes," Douglas G. Carroll, MD, chief, physical medicine and rehabilitation, Baltimore City Hospitals.

"Techniques in Arthritis," B. Stanley Cohen, MD, physiatrist-in-chief, Department of Physical Medicine and Rehabilitation, Sinai Hospital of Baltimore, Inc.

Acceptable for 2 hours Category 1 credit by the American Academy of General Practice.

February 10—8:30 PM—1211 Cathedral St., Baltimare

MARYLAND PSYCHIATRIC SOCIETY

"The Psychatherapies Including Psychaanalysis," A. Russell Anderson, MD, directar and training analyst, Baltimare Psychaanalytic Institute. Discussant: Robert W. Gibsan, MD, medical director, Sheppard and Enach Pratt Haspital.

February 11

HEART ASSOCIATION OF THE LOWER EASTERN SHORE

Teaching sessians for physicians: "Intensive Care of the Patient with Myacardial Infarctian," Jahn J. Curry, MD.

February 16—Sheratan Belvedere Hatel, Baltimare

BALTIMORE CITY DENTAL SOCIETY

3 PM—"Dentistry far the Handicapped," Dr. Soloman Rasenstein
6 PM—Cacktails and Dinner
7:30 PM—Projected Clinics—Mid-Atlantic Pedadantic Study Club

February 20—Sheratan Belvedere Inn

MARYLAND THORACIC SOCIETY

Sixth annual scientific sessian and third annual Trudeau lecture. Registratian, 9:30 AM; lunchean, 12:30 PM; Trudeau lecture, 1:45 PM—"The Diagnasis and Treatment af Pulmanary Mycoses," Jahn P. Utz, MD, Prafessar af Medicine, Medical Callege af Virginia.

Sunday afternaans—2 PM—WMAR-TV, Channel 2

MEDICINE 1966

Spansared by Baltimare City Medical Saciety, Committee an Public Educatian. William Schuman, MD, Chairman.

January 23—"Death on the Raad"
January 30—"Drinking, Drugs and Driving"
February 6—"Yaur Dactar and Medicare"
February 13—"Health Haaxes"
February 20—"Syphilis"

POSTGRADUATE COURSES

UNIVERSITY OF MARYLAND

7. CLINICAL ANATOMY—February 2 through May 25

Under direction of Otto C. Brantigan, MD: Emphasizing the practical application of anatomy and anatomical principles in physical and x-ray diagnasis. Anatomical knowledge is related ta the use of needling in performing diagnastic procedures and in treatment. The caurse is directed taward bath the medical man and the surgeon. It is on aid in preparatian far the American Board Exam.

8. OBSTETRICS—February 10

Under direction of Edmund B. Middletan, MD: Prablems of obstetrical manegement in the prenotal period ond at the time of delivery will be considered.

9. HEMATOLOGY—March 10

Under direction of Carrall L. Spurling, MD: A basic review of diseases of the hemopaietic system. Illustrative peripheral blood and bone marraw slides will be used in connectian with selected case material. Newer techniques of diagnosis ond treatment will be discussed.

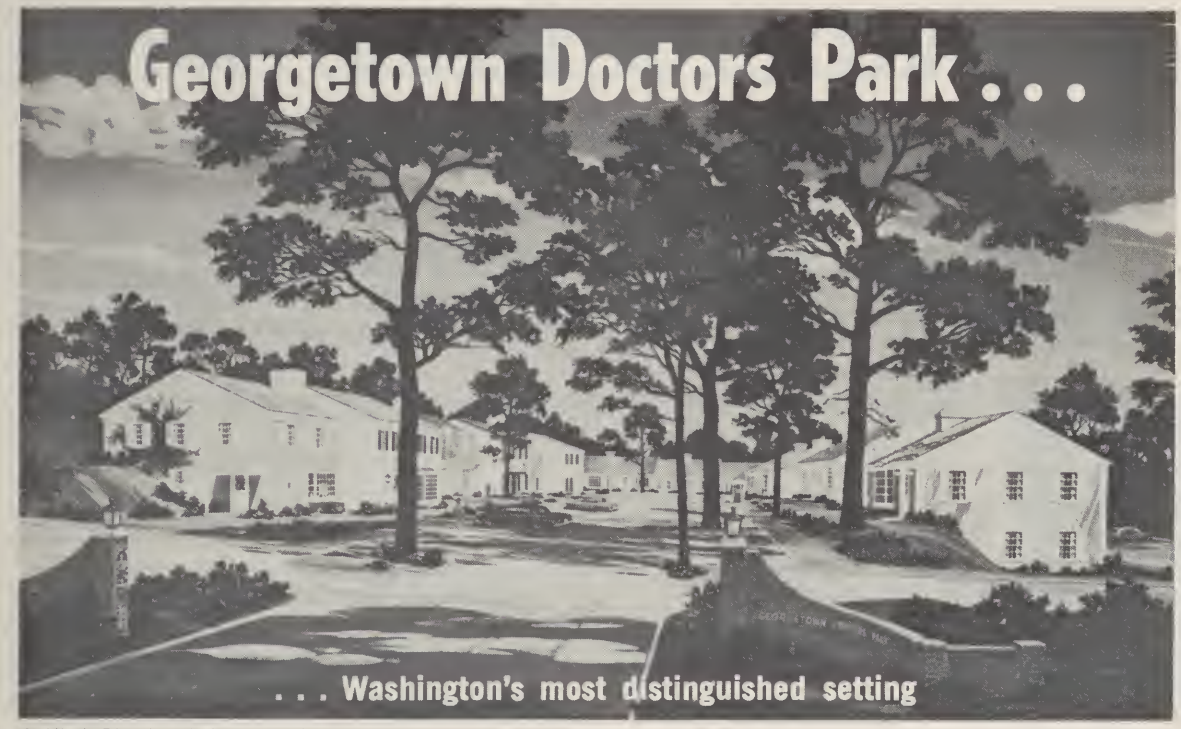
AMERICAN COLLEGE OF PHYSICIANS

Course No. 10—CURRENT CONCEPTS OF INFECTIOUS DISEASES, February 7-11, Jeffersan Medical College, Philadelphio.

Course No. 11—MEDICAL GENETICS, February 14-18, The Johns Hopkins University School af Medicine.

Course No. 12—CANCER, February 21-25, Presbyterian-St. Luke's Hospitol, Chicaga.

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at

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April 27 and 28

Aboard Ship and in Bermuda
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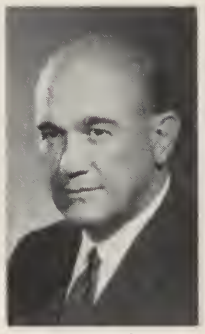
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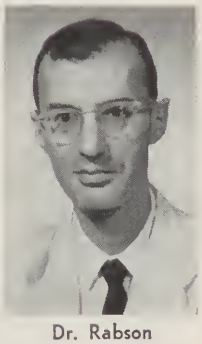
In addition to the speakers listed last month in the JOURNAL and those to be listed in future issues, the following lectures will be given:

The Second annual George M. Boyer, MD, Lecture will be given on Wednesday, April 27, by **JOHN PARKS, MD,** whose subject will be **Families and Physicians.** Dean of The George Washington University School of Medicine since 1957, Dr. Parks is also professor of obstetrics and gynecology there. He was born in Oklahoma, received his MD degree from the University of Wisconsin, and served an internship at the Cincinnati General Hospital and a residency in obstetrics and gynecology at the Wisconsin General Hospital. Dr. Parks was director of the American Board of Obstetrics and Gynecology from 1950 to 1961 and was medical director of The George Washington University Hospital from 1957 to 1965. He is consultant in obstetrics and gynecology at the National Institutes of Health and the Walter Reed Army Medical Center and is president of the National Board of Medical Examiners.



Dr. Parks

On April 28, **ALAN S. RABSON, MD,** will speak on the **Viral Origin of Cancer.** His presentation will be the Harvey Grant Beck Memorial Lecture. Dr. Rabson was born and educated in New York, receiving his MD degree from the Long Island College of Medicine. He was an intern in medicine at the Massachusetts Memorial Hospitals, which included five months training in infectious disease at the Haynes Memorial Hospital, Boston. He was an assistant resident in pathology at the University Hospital in New York City. In 1952 he was commissioned in the U.S. Public Health Service, taking an assistant surgeon course in epidemiology at the Communicable Disease Center, Atlanta. From 1952 to 1953, Dr. Rabson was director of the health study of the Detroit-Windsor International Air Pollution Study, Epidemiology Branch, Communicable Disease Center, Detroit City Health Department. Since 1956, he has been a staff member of the Laboratory of Pathology at the National Cancer Institute, Bethesda.



Dr. Rabson

H. CURTIS WOOD, JR., MD, medical field consultant and lecturer for the Association for Voluntary Sterilization, Inc., has been a practicing obstetrician and gynecologist for 30 years, during which time he practiced at the Episcopal and Stetson Hospitals in Philadelphia. Dr. Wood, upon invitation of Dr. Trimble, will give the annual I. Ridgeway Trimble Lecture on April 27, on **Medicine's Responsibility in the Population Explosion.** Dr. Wood's presentations have been favorably received at the state medical societies where he has spoken. He is well qualified to discuss the medical, social, economic, and legal aspects of voluntary sterilization. He is deeply convinced that involuntary, irresponsible parenthood compounds the most serious problems, from the worldwide population explosion to family difficulties in achieving harmony and emotional stability. Dr. Wood believes that expanded educational programs on all aspects of birth control are urgently needed to help parents limit their families to the number of children they can care for and nurture.



Dr. Wood

More about the speakers next month

ANNUAL MEETING OF MEDICAL AND CHIRURGICAL FACULTY

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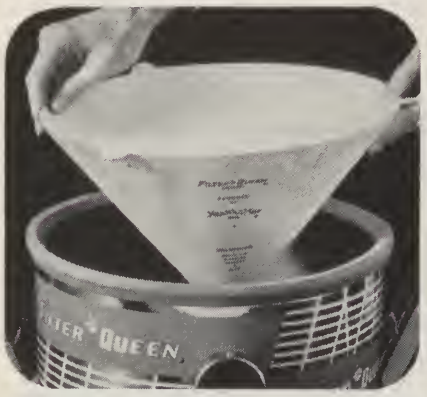


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3 Now turn the machine over to any on witnessing the demonstration, and have he start the machine and apply the nozzle to an place where there is obvious dirt and dus Keep the machine operating for a full minute

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"clean handkerchief" test

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EXECUTIVE SECRETARY'S NEWSLETTER

January, 1966

RESOLUTIONS

Resolutions for consideration at the Faculty's Annual Meeting, April, 1966, must be in the Faculty office before MARCH 1, 1966, in order to be considered. No date has been set as yet for the Reference Committee hearing.

GENERAL ASSEMBLY CONVENES

The State General Assembly opens on January 19 for a 70-day session. The first issue of The Assemblyman is scheduled for publication early in January, 1966, followed by four subsequent issues.

Physicians interested in legislative activity on a state level are urged to peruse items of interest to the medical profession in Maryland.

Fuller details on any particular item may be obtained from the Faculty office. And let us know your views so you may be adequately represented at the State House, Annapolis.

PSYCHIATRIC BEDS IN GENERAL HOSPITALS

On recommendation of the Emotional Health Committee, the Faculty's Council has approved the concept that it "heartily supports" the inclusion of psychiatric services, both in-patient and out-patient care, in all general hospitals in Maryland.

CORRECTION

In a recent communication about ADOPTION, reference was made to the illegality of physicians concerning themselves with adoption in Maryland. Under present laws, Washington and Garrett Counties are excluded from the provisions of this Act.

WELCOME BACK

We are pleased to welcome back Bristol Laboratories as an advertiser in the Maryland State Medical Journal.

TAXES

Physicians are reminded that dues and assessments paid to medical societies are a tax-deductible professional expense.

Physicians are also reminded that they are now covered under the social security provisions of the Medicare law (PL 89-97). Taxes for the 1965 calendar year will amount to $259.20; in 1966 to $405.90.

NOTICE TO PHYSICIANS

The State Board of Health and Mental Hygiene has brought to the Faculty's attention that Mr. Richard D. Culler, "...is not licensed to practice physical therapy in Maryland, never has been and, according to his own statement, graduated from a school of physical therapy which is not approved by the Council on Medical Education of the American Medical Association."

Similar information was obtained from the Physica Therapy Examining Board of D.C.

NEWS NOTES

A. Austin Pearre, M.D., Frederick, has been named college physician emeritus by Hood College in recognition of his 40 years as physician to the Hood campus community.

William J. Peeples, M.D., State Health Commissioner, has been selected to serve on the National Advisory Council on Regional Medical Programs - PL 89-239, the program originally designated Heart Disease, Cancer and Stroke Regional Centers.

Certified a Fellow of the American College of Anesthesiology is John William Pearson, M.B., Towson.

Harold Roll, M.D., has been certified by the American Board of Ophthalmology.

IMPORTANT SUGGESTION

Physicians who order their statements in large quantities might anticipate some changes in form and content as the July 1, 1966, deadline for "Medicare" approaches. Rules and regulations still to be issued may influence the wording of such statements.

Some physicians have suggested that additional wording be included indicating, "this is your permanent record, no duplicates can be furnished.

John Sargeant

Executive Secretary

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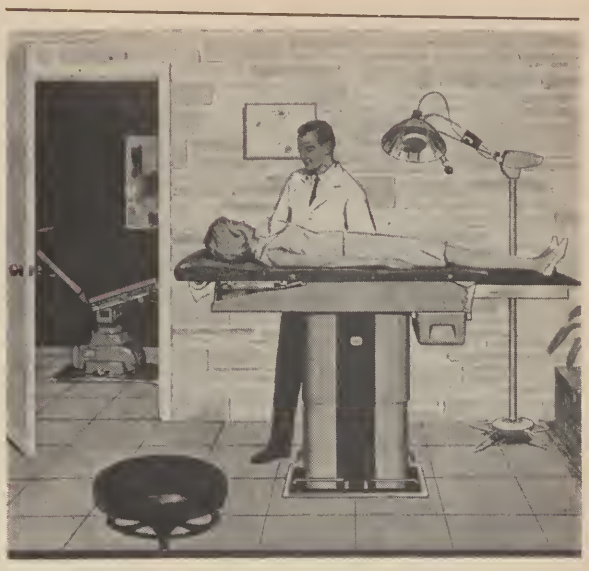
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Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. No cases of photosensitivity have been reported with Tetrex. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dose: 250 mg. *q.i.d.* Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.
Available: Capsules, tetracycline phosphate complex, 250 mg., and nystatin, 250,000 units.

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Maryland State Medical Journal
Vol. 15, No. 1
January, 1966

Editorial

WHY COUNTY MEDICAL SOCIETIES NEED AN EXECUTIVE SECRETARY

ROBERT vL. CAMPBELL, MD
President, Medical and Chirurgical Faculty of the State of Maryland

How well, doctor, is your local medical society doing its job?

Are records and correspondence kept up to date?

Is there adequate communication among your membership?

Do the citizens of your community know where to call for information?

Are their inquiries and their grievances taken care of courteously and promptly?

Is effective liaison maintained with your state society, the AMA, community health agencies, civic organizations, and the press?

Are committee activities coordinated and society projects carried out efficiently?

Are projects started or encouraged by your state and national organizations effectively implemented at the county level?

Is your society making friends for the medical profession in your community?

The officers of your county society—perhaps you are one—are busy physicians with patients to care for, hospitals to visit, books and journals to read, and families whom they would like to see occasionally. The work of the county medical society has become so complex that it is not possible for the officers and the members to perform efficiently all the details that are necessary for a well-functioning organization.

If you have answered "no" to some or all of the questions above, your society should consider employing an executive secretary. A man or woman, assisting part time or full time, depending on your need, can relieve your officers of the many burdensome details. Her—or his—office gives your society an address and a phone number which do not change with each election. It becomes the hub of your society, from which all activity radiates. Correspondence and records are maintained here, and communication at all levels originates here. Continuity continues as officers change from year to year.

The growing number of inquiries from the public and the press, the public service approach, the larger volume of paperwork, the wider scope of medical society activities, and the urgent need for better public relations make it imperative for county medical societies to operate on a businesslike basis.

LUCIE F. MAGUIRE
BALTIMORE CITY MEDICAL SOCIETY

The Baltimore City Medical Society, with headquarters in the Medical and Chirurgical Faculty building, employs a full time executive secretary and an assistant. The society's membership exceeds 1,800. Mrs. Maguire's duties are numerous and varied, covering office management and administration. As secretary to the president and members of the Executive Committee, she relieves these busy officers of many details required to implement actions initiated by the Board of Directors and the membership.

The Baltimore City Medical Society has 20 committees, many of which require setting up appropriate office routines to assure efficient handling of their activities. Statistical reports of membership are prepared from records maintained in the society office. Liaison with the Baltimore City Health Department, Civil Defense Division, and the Boy Scouts of America entail securing and keeping records of physician volunteers for various projects.

Mrs. Maguire was employed by the Medical and Chirurgical Faculty in 1949 and became executive secretary of the Baltimore City Medical Society in 1958. Her previous experience as private and administrative secretary in both commercial and professional offices serves her well in performing her present duties.

DOROTHY E. HOLMAN
BALTIMORE COUNTY MEDICAL ASSOCIATION

Baltimore County Medical Association has approximately 250 members. Mrs. Dorothy Holman spends about 20 hours a week doing the secretarial, bookkeeping and other related duties, such as publicity, helping the program chairman to arrange meetings, and assisting in preparation of the association's membership directory.

In addition to attending all the meetings of the Baltimore County Medical Association, she attends meetings of the Medical and Chirurgical Faculty and of the AMA which might be of particular interest to the association and reports to the members on these meetings.

Mrs. Holman has held her part time position with the Baltimore County Medical Association since 1961. She is also a full time medical assistant in the office of J. Morris Reese, MD. She has a business background, having taken a commercial course at the Baltimore College of Commerce. The course included psychology and commercial law as well as the usual business skills. She then worked at Bon Secours Hospital as secretary to the superintendent for four years. Her diverse duties there even included teaching shorthand to several of the nuns.

JOHN W. LOY
MONTGOMERY COUNTY MEDICAL SOCIETY

The Montgomery County Medical Society, with more than 600 members, requires a full time executive secretary and office staff. John Loy spends five and a half days a week in his management and administrative duties. These include supervising the activities of management and central activities, continuing the actions initiated by the president and the executive board, administering policies made by the society, and maintaining the society's membership and financial records. As managing editor of the county society's *Medical Bulletin*, he performs the editorial tasks necessary to its monthly publication. He maintains liaison and holds committee membership and appointments in and with county civic and lay health groups.

Another facet of his job includes that of general manager of the Bureau and Exchange, a $56,000 annual enterprise of the Montgomery County Medical Society. This is a financially self-sustained operation which carries out physician referrals, emergency call system, and the county-wide disaster program.

John Loy has been executive secretary of the Montgomery County Medical Society for nine years. His earlier experience included various positions of medical administration in the United States Army. He supplemented this experience with university courses in hospital and medical administration, money and banking, personnel administration, and applied psychology.

Six component societies in Maryland have an executive secretary. Baltimore City and Montgomery County have headquarters with a full time staff. Baltimore, Prince George's, Wicomico, and Washington Counties employ part time executive secretaries.

At least seven other county societies have a large enough membership to support one, and some of the smaller societies might consider joining with neighboring societies to employ a regional secretary.

I'm sure that every community has some likely candidates for the position. The sketches of some of our executive secretaries might suggest to you the type of person you would require. Generally, such a person should possess tact, executive capabilities, diplomacy, and an ability to get along with people. He or she should have office skills and be able to communicate effectively. Specific qualifications would depend upon your particular needs.

The technique of acquiring a part time secretary is not too involved. Your state society would be glad to give you advice. A visit or inquiry to county societies of comparable size to yours who have travelled this road might be informative.

145 W Washington St
Hagerstown, Md 21740

DAVID A. McNAMEE
PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

Prince George's County Medical Society, with a current membership of about 200, employed David McNamee as a part time executive secretary in 1950. He was then working as assistant superintendent of the Prince George's General Hospital. Since the society was using the hospital as its meeting place, Mr. McNamee found it easy enough to do the little extra paper work required by the society.

His background at the time consisted of a degree in business and public administration from the University of Maryland. In 1953 he left the hospital to study law and now maintains a full time law practice. Throughout this period he has continued to assist the Prince George's County Medical Society.

Mr. McNamee described his duties as "the usual run of the mill for an executive secretary," but did not elaborate. His work load varies. There are many days when he does not spend an hour a day on the task; there are others when "I spend too many."

JOYCE HARLACHER
WASHINGTON COUNTY MEDICAL SOCIETY

With a membership approaching the 100 mark, the Washington County Medical Society is the most recent one to employ an executive secretary. In an office in her home, Mrs. Joyce Harlacher works an average of about 60 hours a month on behalf of the society. She is employed on a fee for service basis.

She has established files on several hundred subjects, publishes a monthly newsletter for the society, assists the executive committee in carrying out its duties, performs the necessary secretarial work, writes news releases and features for the local newspapers and radio stations, has organized and maintains a speakers bureau for the community, assists the committees in their duties, and attends meetings of the Washington County Medical Society, as well as those of the Medical and Chirurgical Faculty, the Medical Society Executives' Association, and the AMA Public Relations Institute.

Mrs. Harlacher holds a BA from the Juniata College, where she studied history and journalism. Her background is in the news media: she has written continuity and local commercials for radio and television, was a correspondent for a city newspaper, and has worked in promotion and publicity.

KIT HARGREAVES
WICOMICO COUNTY MEDICAL SOCIETY

Wicomico County Medical Society, with about 70 members, employs its executive secretary on a part time hourly basis, according to its needs. Mrs. Kit Hargreaves, working in her home, also acts as executive secretary for the Peninsula General Hospital and operates her own mimeographing service.

Activities pertaining to publicity and public relations for the society form a large part of her duties. Mrs. Hargreaves' background includes 12 years in radio and two years in the administrative office of the Peninsula General Hospital, where she did much of the hospital's public relations.

Mrs. Hargreaves acts as a clearing house for information for officers and members of the society, the news media, and the public. She maintains liaison with the local voluntary and other health and related agencies; edits the local newsletter, prepares news and feature articles for local radio and TV, newspapers and AMA publications; keeps abreast of new developments in health insurance, medical legislation, innovations in medical practice, and many other areas of interest to the members; does resarch or obtains special information as requested; and assists in planning and implementation of special projects. In addition, she performs all the office management, bookkeeping, and secretarial functions required by the Wicomico County Medical Society.

Mrs. Hargreaves is active in the Medical Society Executives' Association, which she finds a valuable source of information about medical societies' activities throughout the country. She is a member of the Membership and Attendance Committee of the MSEA.



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RESOLUTIONS

Important Notice for Component Medical Societies and Individual Members of Medical and Chirurgical Faculty

All resolutions or recommendations for presentation to the House of Delegates must be in the Faculty Office by Tuesday, March 1, 1966, which is eight (8) weeks prior to the Annual Meeting. This is referred to in the following quote from the Faculty Bylaws:

. . . A Reference Committee of five members of the House of Delegates to which all Resolutions involving questions of Faculty policy, except those proposed by the Council or committees of the Faculty, shall be referred at least eight weeks prior to any regular session . . . of the House of Delegates. All such resolutions shall be reported to the House of Delegates with the committee's recommendations, provided that, with the sponsor's approval, the committee may revise any resolution.

The meeting of the Reference Committee is open to all members of the Faculty in good standing, who may attend and express their opinions. Notice of the date and place of the Committee meeting will be sent to all members.

RESOLUTIONS for April 1966, House of Delegates must be in the Faculty Office by TUESDAY, MARCH 1, 1966

Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, OCTOBER 28

Joint meeting with Executive Committee of Hospital Council

1. A report was made by the Hospital Council on Utilization Committee activities. This was primarily a report of progress and interpretation to physicians.

2. Discussion of problems connected with the Medicare law took place. The Hospital Council was told of the Faculty's policy that participation was up to the individual physician. Copies of information mailed to physicians on this subject are to be sent to hospital administrators as well.

3. A report was made on areawide health facilities planning. This will be discussed further at the next meeting of the Faculty's Executive Committee.

4. Certain problems of physician-hospital relations were considered, especially in relation to the corporate practice of medicine. Of particular concern was the matter of payment directly to physicians rather than to hospital funds. Specific answers are to be sought as to what arrangements are or are not ethical.

EXECUTIVE COMMITTEE, NOVEMBER 18

1. After ascertaining the legality of billing for MMPAC dues along with Faculty and component society dues, it was voted to do this for 1966. In subsequent years, this can be included as a printed line item on the Faculty dues bill, subject to certain legal requirements.

2. Physicians Defense was ratified for a member.

3. Approval was given to printing cards listing phone numbers and contacts of hospital outpatient services in Maryland. This information will be included in a future mailing to Faculty members.

COUNCIL, NOVEMBER 18

1. A summary of educational fund expenditures and appropriations was approved and is to be distributed to all Faculty members in the next membership mailing.

2. The dues of two physicians were remitted because of illness.

3. Emeritus membership is to be recommended for J. Marion Bankhead, MD, Montgomery County, and J. E. Bradley, MD, Baltimore City.

4. The following recommendations of the Ad Hoc Finance Committee were adopted: 1) that securities of the Faculty's investment program be registered in nominee form, and 2) that the Bylaws Committee be asked to prepare an amendment to give the Finance Committee permanent status.

5. Legal defense was ratified for members requesting it.

6. Announcement was made of the settling of legal cases involving Faculty members.

7. The following actions are to be taken in connection with the Faculty's Diabetes Subcommittee and the Maryland Diabetes Association:

1) The Maryland Diabetes Association is to be asked to use the services of physicians for physical examination of children attending the diabetes camp; properly qualified paramedical personnel should be used for screening before examination by physicians.

The use of optometrists for eye examinations would be unethical.

2) A letter is to be sent to the Maryland Diabetes Association reaffirming the Council's opposition to use of the name Camp Med-Chi for the diabetes camp.

3) As soon as possible, the telephone listing of *Diabetes Committee of Maryland* should be changed to *Diabetes Committee of the Medical and Chirurgical Faculty of Maryland.*

8. The following recommendation of the Policy and Planning Committee was considered:

> **That the Faculty make application to the federal government, when appropriate, for construction funds for library purposes (matching up to 75% of cost of construction); and that the Library Committee, in cooperation with the Policy and Planning Committee, give serious thought and consideration to an expansion and coordination of services with hospital libraries throughout the state.**

The concept expressed in this recommendation was approved in principle, but no actual application for funds is to be made until further details are available.

9. A recommendation was adopted which heartily supports the inclusion of both inpatient and outpatient psychiatric services in all general hospitals in Maryland.

10. Council meeting dates for 1966 were approved.

11. Saturday, January 29, has been set for the special meeting of the Faculty's House of Delegates that has been petitioned for January, 1966.

12. The Guidelines for Expenditures from Educational Fund, drafted by the Public Relations Committee, was adopted. It was expressly understood that specific expenditures must be approved by the Council or the House of Delegates. This information is to be included with the financial status of the educational fund in the next Faculty mailing.

13. Anticipated state and federal legislative activity for 1966 was reviewed. The suggestion that reports on legislative activity be made to component societies weekly over the MEDIC network is to be pursued with the MEDIC committee. Details of anticipated legislation will be listed in the first issue of *The Assemblyman* in early 1966.



14. A sum of up to $200 from the educational fund was granted to the Subcommittee on Child Welfare for an exhibit on the Battered Child Syndrome to be used at the Faculty's annual meeting and throughout the state afterward.

15. The secretary of Health, Education and Welfare was notified that the Faculty prefers Blue Shield as the fiscal administrator for Medicare. It was made clear that this does not imply endorsement of the Medicare law.

16. The Mediation Committee reported on a survey of physicians associated with lay laboratories. Three indicated severance of their relationship; five indicated terms which were deemed ethical; and one, in violation of ethics, was advised to terminate the relationship.

17. A representative from E. D. Rosenfeld Associates, Inc., New York City, outlined activities in connection with a hospital survey being conducted for the Maryland Hospital Commission. He solicited opinions from Council on various subjects, such as hospital utilization and construction.

18. A recommendation was adopted that payments to podiatrists for care rendered on the prescription of a physician to medical care patients in nursing homes be endorsed.

19. Upon request to reconsider its policy in connection with Blue Shield payments to physicians for diagnostic x-ray procedures, the Council voted to let the present policy stand.

20. Walter S. Caution was placed on retirement status.

21. The Council was requested to take action forbidding the denial of membership in the Baltimore City Medical Society to new applicants. Since no specific cases of denial of membership could be produced, the Council declined to take any action until details were made available.

22. On recommendation from the Fee Schedule Committee, the Maryland Medical Service, Inc., is to be advised that in establishing fees for new procedures in various schedules, the Faculty is willing and anxious to 1) make data available in these areas from its files; 2) select names of physicians who perform these procedures so that Maryland Medical Service, Inc.,

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may contact representative physicians doing such procedures; and 3) suggest names of physicians who truly represent the profession in performing such procedures, for Maryland Medical Service, Inc., to contact.

23. A schedule of fees charged to the average semiprivate patient, compiled by the Fee Schedule Committee, was adopted with the notation that the Council may make amendments at its next meeting if necessary. The Fee Schedule Committee is to be required to review this schedule annually, or more often if necessary.

24. A revised report on tuberculin testing in Maryland schools was adopted.



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Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

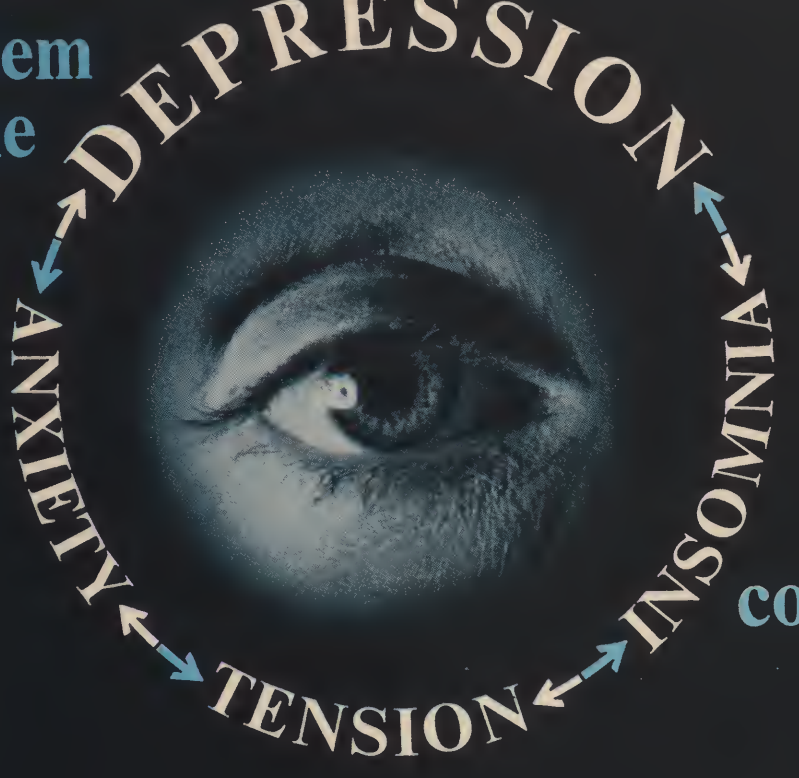
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Frederick Memorial Hospital Presents

Postgraduate Education has a long tradition at the Frederick Memorial Hospital. The articles appearing in this issue represent a facet of postgraduate education as conceived and practiced at our institution.

After many years of abortive efforts to create a durable and dependable postgraduate education format, one of our self-searching studies led to the current program. The basic idea which evolved concerned the goal we aim to attain. The most we could hope to gain from postgraduate education was a stimulation of the individual's interest in pursuing the study of medicine in his postgraduate years on his own initiative.

To accomplish this goal, the meeting time was analyzed and a great deal of thought went into the final selection.

Next, the decision was made to precede the noontime meetings with a superior, gratuitous buffet luncheon. With the splendid cooperation of the administrator, this feature was quickly effected.

The problem of programming was resolved by allowing for nine annual outstanding lecture presentations by speakers from outside our staff. The cost of these speakers is met through a voluntary assessment of the staff, which has always succeeded in maintaining solvency. It further gave all contributors a personal sense of participation in the programs.

The subject for any year encompasses one anatomic system such

RENAL
Postgraduate Program in DISEASES

as kidney, hematopoietic, gastrointestinal, etc. The selection of individual lecture topics is made one year in advance. The system selection is made two years in advance. The topics are selected after extensive correspondence with authorities in the field throughout the country. After the topics are selected, outstanding speakers are engaged about one year in advance of the presentations. This is done for each of eight lectures. The final lecture consists of a panel of visiting experts in this field to whom local case presentations are made for detailed discussion. This final session is extended to a three-hour period.

While the central theme is carried on at the monthly postgraduate education meeting, each monthly service meeting attempts to correlate and coordinate the central theme in their department conferences, with an analysis of local cases.

It is from such correlation that the Medical Service in 1964-65 presented a series of talks by members of the hospital staff on renal diseases, which is the main theme of the postgraduate program for the year.

This format has been most successful in bringing a high percentage of the staff physicians to the meetings. Still, the Postgraduate Education Committee continues to acknowledge that the ultimate goal is the sustained, avid study by the individual staff physician.

Robert J. Furie, MD



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Polycystic Disease of the Kidneys

LOUIS R. SCHOOLMAN, MD

When I was assigned the first talk of this renal program, I was given a list of diseases. I chose polycystic disease because I had observed and treated a patient from start to finish. I learned many lessons from this patient. I learned the difference between azotemia and uremia, when to press treatment, and the value of continued antimicrobial therapy. I learned that the diagnosis of polycystic disease need not be a sentence of imminent death and that the patient may carry on a normal family life for years. I relearned to respect and admire the quiet courage with which many patients meet the increasing afflictions of a chronic fatal disease.

I will confine this paper to congenital cystic disease of the kidneys and will not go into simple cystic disease or medullary cystic disease, which clinically resembles Addison's disease. I will first describe my case and then follow with a short review of the disease.

CASE REPORT

A 35-year-old farmwife, mother of an 11-year-old son, was admitted here October 30, 1950, two weeks after she had noticed a tender enlarging mass in the left flank. After intravenous and retrograde pyelograms were done, she was operated on for a kidney tumor. The surgeon found a polycystic kidney and did a nephrotomy. Her records show blood pressure 120/70, hemoglobin 13 grams, NPN 47 and 1+ albuminuria with 20-30 red blood cells and an occasional white blood cell.

When she first consulted me November 30, I learned that she was an only child and that her

The typical patient with congenital polycystic disease of the kidneys has a family history of renal disease and may expect symptoms to appear in the thirties or forties. These symptoms frequently are dragging lumbar or abdominal pain accompanied by abdominal enlargement. There already may be a history of recurrent urinary infection or renal colic.

On examination, one or both kidneys will be felt as hard irregular masses. Hypertension may be present, and the urine probably will show albumin and white blood cells. The intravenous pyelogram will show elongated calyces with some blunting and irregularity of outline. At present, such a patient may ordinarily expect to live about 10 years after the onset of symptoms but possibly may have a normal lifespan. Enlarging kidneys, increase in severity of symptoms, progression in associated hypertensive vascular disease, or decreasing renal function indicate a poor prognosis.

We are justified in a more optimistic attitude toward such patients. Alert medical supervision, the use of increasingly efficient antimicrobials, and carefully controlled hemodialysis and peritoneal dialysis can prolong life greatly. Perhaps in the near future kidney replacement will cure polycystic disease.

father and paternal aunt had polycystic kidney disease. She had had pneumonia without complication at 3 years and, 7 years later, scarlet fever which was followed by tachycardia for several months. Her only operation before the nephrotomy was a T&A in childhood.

She was 66 inches tall and weighed 124 pounds. Pulse was 90 and blood pressure 140/100. I found a tender mass about the size of a small grapefruit in the left flank. Her hematocrit was 40 and NPN 97.5. The urine was 1.009 and negative for albumin and sugar.

One month later the NPN was 45. During the next year, at monthly visits, she showed no appreciable change and did not complain of pain in the left flank except when jolted by a bump in the road. In the second year, I saw her every two to four months and found no appreciable change.

In June, 1953, I first noted enlargement of the right kidney. She weighed 139, had a blood presure of 160/98, and showed no albumin. During the next 18 months, the blood pressure rose gradually to 150-170/100-110 and pulse 100 to 120. She complained of frequent headaches and nervousness. Venipunctures were so difficult that only rarely was blood drawn for NPN. In October, 1954, it was 42 mg%.

After January, 1955, albuminuria and clumps of white blood cells became constant findings. Sulfisoxazole (Gantrisin), usually, and, at times, streptomycin and penicillin mixture controlled the pyuria and bouts of left flank pain but did not affect the proteinuria. She continued in her usual life and did all the duties required of a housewife and farmwife.

In April, 1956, bilateral flank pain developed. The left kidney had doubled in size, and the right was about the size of a large grapefruit. While the patient was on chloramphenicol, the urine was negative on culture. She felt better while taking this antibiotic and continued it at a dose of 250 mg twice a day. The blood pressure remained the same, but her weight gradually increased to 146 by December, 1956. In June, 1956, glycosuria first appeared, which, thereafter, was persistent from a trace to 1+. Antimicrobial drugs were given daily with chloramphenicol alternating with sulfonamides. She did not tolerate nitrofurantoin.

In September, 1957, she complained of almost constant nausea. Findings were: pulse 120, blood pressure 214/120, weight 143 pounds, urine 1.010, albumin and sugar 1+, microscopic, 10-15 white blood cells and many casts. NPN was 57 mg and hematocrit 32. Chlorpromazine helped to control the nausea. The enlarging left kidney prevented her from lying on her abdomen, so she was more comfortable sitting up. Headaches became almost constant.

In February, 1958, the left kidney mass became larger and more painful and tender. The NPN was 64 and fasting blood sugar 212. In March she vomited intermittently. The left kidney extended 18 cm below the left costal arch anteriorly. The blood pressure was 220/110, and her weight had dropped to 140 pounds. In April she complained of itching. By this time venipunctures were so very difficult that I spared her as much as possible and did blood chemistries rarely. (We did not have facilities for microchemistry.)

I began diabetic treatment first with tolbutamide (Orinase), then chlorpropamide (Diabinese) and phenformin hydrochloride (DBI), and finally insulin. None of these drugs controlled the glycosuria. It would show 1+ to 2+, and her nonfasting blood sugar would be slightly more than 200 mg%. The glycosuria and hyperglycemia were not caused by chlorothiazide, for it was not yet available. She had no family history of diabetes, which made me wonder whether cysts of the pancreas had developed.

By June, 1958, she was deeply bronzed and complained greatly of itching. She would regularly vomit her midday meal. There was no blood or coffee ground staining of the vomitus. On June 27 she entered the hospital complaining of an acute pain in the right kidney area, probably caused by a hemorrhage into a renal cyst. Both kidney masses were very large. The blood pressure was 180/100, and the urine showed 1.010, albuminuria 1+, glycosuria 1+, and white blood cells too numerous to count. Culture showed an alpha streptococci sensitive to all antibiotics, sulfonamides and nitrofurantoin. The hemoglobin was 8.5 gm, hematocit 26, NPN 103, fasting blood sugar 144, potassium 4.4 mg, and sodium 122 mg.

X-ray films showed large renal masses but no stones. During her week in the hospital, she did not vomit while on a rice diet. Her NPN dropped to 83 and the blood pressure to 180/90.

She left the hospital improved but thereafter

led a restricted life. She was unable to do anything but the lightest housework. She resigned her highly valued position as president of the county homemaker's club. She had passed the turning point of her disease, both physically and psychologically.

By August, while no stronger, she felt a great deal better. She told of a feeling of sudden disappearance of the right renal mass associated with a great increase of urine. Vomiting had not recurred, and the pruritis had disappeared. The blood pressure still varied from 204/90 to 250/110, and her hemoglobin from 7.5 to 8 gm during the next five months.

In January, 1959, she had severe pain of the left flank accompanied by gross hematuria. The mass was definitely larger. One month later she felt better. Her hemoglobin was 6.3 gm, NPN 64, nonfasting blood sugar 212. The urine showed 2+ albumin, 3+ sugar, and many white blood cells.

By May, 1959, nausea and vomiting had returned. The distention of her abdomen increased, and meperidine (Demerol) was required to relieve pain. Glycosuria persisted despite the use of insulin.

On May 24 the patient was readmitted for six days because of severe diarrhea and anasarca. The NPN was 80, blood sugar 81, hemoglobin 7 gm, and hematocrit 21. The urine was 1.008 and showed a trace of albumin and no sugar or acetone and only 6 to 7 white blood cells and 8 to 10 red blood cells. The culture was negative. She was treated simply with a strict Kemper rice and fruit diet. The NPN dropped to 38.

After she returned home, vomiting recurred daily. Her mouth and tongue were sore and showed purpura of the buccal mucosa and hyperkeratosis of the tongue. Her hands showed tremor and legs 4+ edema which extended to the thighs. Her general condition deteriorated rapidly. She became lethargic and almost comatose.

On August 5, 1959, she was readmitted because of the anasarca and hydrothorax. Her pulse was 120, blood pressure 200/100, hemoglobin 5.2 gm, hematocrit 18, NPN 130, fasting blood sugar 111, total protein 4.5, blood sodium 128 mEq/liter, potassium 5.4 mEq/liter, calcium 12mg, and phosphorus 10.8. The urine showed specific gravity 1.006 with a trace of albumin and sugar, 4-6 white blood cells, and red blood cells too numerous to count. X-ray films of the chest showed enlargement of the heart with suggested pericardial effusion and bilateral pleural effusion. The EKG showed myocardial ischemia and left ventricular hypertrophy. I tapped her chest and got 100 cc of clear fluid from the right side but only 50 cc from the left side. She lapsed into a deep coma and died August 10, age 44, nine years after the clinical onset of her disease.

Her husband refused an autopsy. I was particularly disappointed in not knowing whether or not she had cystic disease of the pancreas which may have caused diabetes.

POLYCYSTIC DISEASE OF THE KIDNEYS

Polycystic disease is the most prevalent renal cystic disease. It is inherited as a dominant non-sex-linked disease emerging clinically at two prominent age peaks, infancy and middle age. The progressive dilatation of the renal tubules leads to obstruction, infection, rupture of cysts, bleeding, or chronic renal faliure. Other associated anomalies, such as cysts in other organs and berry aneurysm of the cerebral arteries, may be present. Sporadic cases are found, but surveys in large families usually show that half of the members develop clinical signs of the disease. Often the adult disease emerges after the next generation has been planted.

No single theory of pathogenesis is generally accepted. Older theories such as fetal papillitis with secondary fibrosis and obstruction, cyst formation as a neoplastic process, congenital syphilis, and fetal interstitial nephritis no longer seem valid.

Bagg[1] has produced a polycystic kidney experimentally. He exposed the abdomen of one generation of mice to unfiltered irradiation and found in the third and fourth generation various congenital anomalies including polycystic kidney, horseshoe kidney, and renal aplasia. He proved that the tendency to these congenital renal anomalies was inherited as a Mendelian recessive. Research in this direction, in view of the widespread use of diagnostic and therapeutic irradiation and radioactive isotopes, may be rewarding.

The most tenable theory is the one first suggested by Felix[2] and elaborated by Kampmeier,[3] that the uriniferous tubules of certain generations fail to atrophy or reunite with the collecting tubules. Thus, a functioning glomerulus with no outlet produces multiple glomerular and tubular

cysts. The development of associated renal arteriosclerosis greatly influences the progression of polycystic disease and may be the major factor in the initial production of symptoms in adult life.

The pathologic appearance is unmistakable. The kidneys are enlarged and often asymmetrical. They have a nodular surface produced by projecting cysts which may be filled with water, serous, hemorrhagic, or viscid fluid, or clear urine. The cut surface shows the entire parenchyma honeycombed by cysts protruding from various levels. Cysts may coexist in the spleen, pancreas, lungs, and particularly in the liver, but are rarely clinically significant. Interruptions of the elastic laminae of small renal arteries, ruptured arteries, and microaneurysms are found in the renal parenchyma. Degenerative changes from pressure, calculi, and secondary infection may be present. Many cases of renal carcinoma and rare cases of papillary carcinoma have been reported in polycystic kidneys. An important fact to remember clinically is that 20% of polycystic cases have intracranial aneurysms, and 4% of patients with clinical cerebral aneurysms have polycystic disease.

Table 1

Associated Congenital Anomalies Encountered in 46 Cases of Polycystic Disease of the Kidney at Necropsy

Associated Congenital Anomalies	Cases	%
Polycystic liver	15	33
Polycystic pancreas	4	9
Polycystic spleen	1	2
Cardiac defects	4	9
Defects of nervous system	2	4
Genitourinary defects (other than polycystic kidney)	6	13
Defects of gastrointestinal tract	3	7
Defects of the musculoskeletal system	2	4
Total	37	81

Diagnosis of the infantile type is usually made by palpation of bilateral renal masses, by x-ray findings, or by development of uremic symptoms such as vomiting, dehydration, and abdominal distention. The adult type may be asymptomatic for many years and then may be only a chance finding on x-ray examination or autopsy.

The presenting complaints of the 207 cases collected at the Mayo Clinic by Rall and Odel,[4] which form the basis of all the tables shown, had the diagnosis verified by intravenous or retrograde pyelogram or examination of the kidneys at the time of operation or autopsy.

Table 2

Clinical Data Presenting Complaint or Findings

	Cases	%
Lumbar or abdominal pain	58	28
Presence of abdominal mass	42	20
Elevated blood pressure	35	17
Frequency, urgency or burning on urination	36	17
Painless hematuria	26	13
Hematuria and renal pain	21	10
Kidney failure (edema, uremia, etc.)	2	1
FINDINGS ON PHYSICAL EXAMINATION		
Elevated blood pressure (more than 140 mm Hg systolic or 90 mm diastolic)	146 (of 200)	73*
Palpable, enlarged kidney or kidneys	150 (of 207)	72†

*% of 200 cases in which blood pressure was recorded.
†% of 207 cases.

These symptoms include lumbar or abdominal pain in 28%; palpable mass in 20%; hypertension 17%; bladder symptoms such as frequency, urgency, and dysuria in 17%; painless hematuria in 17%; and painful hematuria in 10%. Some patients may appear with any of the manifestations of renal failure. Hypertension and palpable enlarged kidneys were present in about 75% of the patients at the time of diagnosis. Kidneys weighing 6 kg or more produce weakness, a dragging sensation, displacement of other organs, and increased abdominal girth. The pain present in 20% of the patients has no definite pattern. It was located in the lumbar region or upper or lower part of the abdomen and was usually nagging and dull but could be colicky. This more severe pain was usually caused by the passage of blood clots or calculi.

The most common laboratory findings are albuminuria, pyuria, and hematuria. Increased BUN in more than one third of these presenting patients indicates how long they were able to get along without azotemic symptoms. Kidney stones were found in 14%, suggesting that hyperparathyroidism secondary to long renal failure may be

Table 3

Laboratory Studies

	Cases	%
Albuminuria		
None	46	22
Grade 1 to 2+	143	69
Grade 3 to 4+	18	9
Hematuria		
None	156	75
Grade 1 to 2+	33	16
Grade 3 to 4+	18	9
Pyuria		
None	64	31
Grade 1 to 2+	121	58
Grade 3 to 4+	22	11
Elevated Value for Blood Urea (more than 40 mg/100 cc)	72 (of 198)	36
Associated Nephrolithiasis	29	14



Fig 1

the cause. Of the 29 patients who had stones, only 11 had high BUN; and this is the same incidence of azotemia found in those without stones. Stagnation of urine and infection seem more likely to have caused the calculi (fig 1).

The important x-ray findings are enlarged or displaced kidneys with various densities, loculation or calcification, elongated pelves, crescentic deformities of calyces, hydronephrosis, and other obstructive phenomena. The infantile type of cyst is best diagnosed by observation of dye in the kidneys retained up to 72 hours.

Less than 10% of polycystic disease is unilateral. Complications of polycystic disease are varied. Many patients present or die with complications such as vascular accidents from ruptured cerebral aneurysms or hypertensive disease, secondary pyelonephrosis, infected cysts, perinephritic abscesses, gross hematuria, calcification of cyst walls, and formation of urinary calculi and renal carcinoma. Subdiaphragmatic abscesses from ruptured infected cysts have occurred.

The infantile type carries a poor prognosis. Infants die rapidly from uremia or complications. The adult type may be latent and may not shorten life. A local man known to have masses in both flanks at 68 had the diagnosis of polycystic disease made by IVP at 74, at which time his NPN was 34. He died at 82 of a stroke. But usually the disease is progressive and leads to hypertension, uremia, vascular accidents, and infection with death occurring in the fifth or sixth decade.

Life can be prolonged by continuous medical care and treatment of infection and acute obstruction, management of chronic uremia, and avoidance of or special care during pregnancy. The average age at death was 49.3 years, excluding those dying under six months of age. The average life after the onset of symptoms in a carefully followed series of 43 patients was 9.3. The 17 patients whose onset of persistent azotemia (BUN

Table 4

Necropsy Data in 46 Cases Concerning Age at Death

Age (Years) Distribution	Cases	%
0-1	9	20
1-9	0	0
10-19	2	4
20-29	1	2
30-39	2	4
40-49	11	24
50-59	11	24
60-69	5	11
70 or more	5	11
Total cases	46	100

40 mg% or higher) was fairly accurately determined, lived on an average of 2.2 years. One survived five and a half years.

Table 5

Cause of Death in 46 Cases

	Cases	%
Kidney failure with uremia	9	20
Myocardial infarction	6	13
Cerebral hemorrhage	4	9
Cardiac failure	3	7
Multiple congenital anomalies	3	7
Prematurity	3	7
Generalized peritonitis	6	13
Postoperative, 4		
Postirradiation, 1		
After perforated appendix, 1		
Paralytic ileus (postoperative)	1	
Lobar pneumonia	1	
Bronchopneumonia	2	
Pulmonary edema	1	
Suppurative bronchitis	1	
Lupus erythematosus	1	
Spongioblastoma multiforme	1	
Pulmonary tuberculosis	1	
Hemorrhage from ruptured esophageal varices	1	
Cerebral thrombosis	1	
Basilar meningitis	1	

Only 20% of the patients died directly from renal failure. Even if the deaths from the complications of the hypertension accompanying polycystic disease, such as myocardial infarction, cardiac failure, and cerebral hemorrhage, were excluded, the incidence was less than 50%.

At present, the treatment of polycystic disease is medical. Various surgical procedures such as marsupialization, bivalving with unroofing, puncture and aspiration, and unilateral nephrectomy have been tried and have failed. Decompression or heminephrectomy is justified only when extrarenal obstruction develops. Treatment of urinary infections and chronic renal failure must be carried out in polycystic disease just as in other renal diseases. Recent studies emphasize the futility of expecting cure of urinary infections when urinary tract obstruction is present, but they also point out that these infections can be controlled by continued use of antimicrobial drugs selected by tube sensitivity tests. Penicillin is still one of the most valuable drugs in this field. Gross hematuria should be treated by bedrest, and any significant anemia with transfusions. Careful management of the hypertension is essential.

Hemodialysis has been used successfully for transient exacerbations of renal failure caused by infection, obstruction, dehydration, or hypotension. It may occasionally result in prolonged improvement even in apparently moribund patients. The history of a recent good urinary volume is a good guide in selecting patients for dialysis. Peritoneal dialysis can also be used. It takes longer and its effects do not last as long, but it requires so little equipment and supervision that it can be done anywhere.

Treatment of the patient involves his family. If the patient has children, about half may develop the disease. The physician must handle this situation with great discretion so as to avoid producing excessive guilt on the part of the parent and blame on the part of the children. The children and siblings of the patient should be encouraged to have frequent examinations to detect the disease as early as possible.

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Nitrofurantoin—*Furadantin*
Phenformin hydrochloride—*DBI*
Sulfisoxazole—*Gantrisin*
Tolbutamide—*Orinase*

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A case of nephrotic syndrome is reported. The cause has not been determined. Treatment has been of six years duration, and the patient's course has been complicated by signs and symptoms of cholecystitis, possible peptic ulcer, and possible hyperthyroidism. Excessive proteinuria continues despite almost five years of steroid therapy, but no other abnormalities of renal function have been demonstrated.

THE NEPHROTIC SYNDROME

HENRY V. CHASE, MD

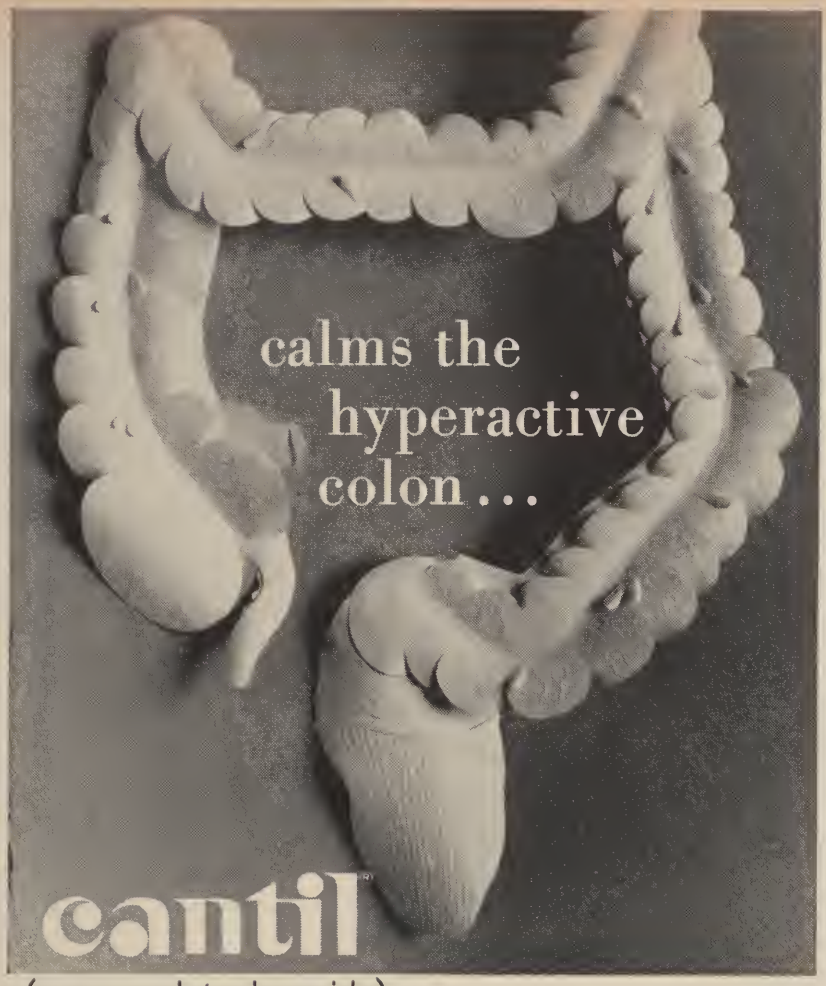
This patient was selected as representative of the nephrotic syndrome for several reasons. First, she has been studied thoroughly, and close personal follow-up has extended over a period of six years. Second, the patient presents a number of features that provoke discussion. Her course has been most instructive and continues to be a challenge for the future.

CASE REPORT

The patient, a 37-year-old, white, married woman, was first seen on March 1, 1957. She complained of tiring easily. She dated the onset of her illness back to June, 1956, when she had developed a rather extensive contact dermatitis, eventually attributed to metal hypersensitivity. From July, 1956, to December of the same year, she was treated with steroids and developed edema of the lower extremities and elevation of blood pressure. Frequent upper respiratory infections associated with a persistent, hacking, nonproductive cough were noted. All of these disappeared when steroid therapy was discontinued.

Before June, 1956, her past health had been excellent. In 1942, during the last trimester of her only pregnancy, she had extensive swelling of both lower extremities. This cleared spontaneously after delivery. She was not told that she had any kidney trouble or elevation of blood pressure. Six years later, while living in California, she developed a lower urinary tract infection diagnosed by an urologist as cystitis. Cystoscopic examination was performed and no specific therapy was given. She made an uneventful recovery.

Her paternal grandfather was a diabetic, but there is no family history of allergy, thyroid trouble, tuberculosis, or kidney disease. Her father died of a coronary thrombosis at the age of 60. A system review revealed no significant information.



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IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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On initial physical examination, blood pressure was 150/90; temperature 99.4° (oral), weight 120 pounds, and pulse 70/min. She appeared older than the stated age of 37. Skin texture was normal. One spider nevus was found on the right arm, and there was a small area of healing erythematous rash on each of her fingers. The mucous membranes were moist and of good color; her hair appeared normal. The thyroid was not palpable. There were no palpable lymph nodes in any part of the body except for several shotty glands in the inguinal regions. Examination of the eyes was not remarkable except for a slight degree of exophthalmos and a questionable lid lag. The former has been present for many years and was considered a family trait. Her fundi appeared entirely normal. The pharynx was slightly injected but was otherwise unremarkable. Both breasts were fatty and without palpable lumps. There was no gross deformity of the chest cage. Lungs and heart appeared normal. The abdomen was flat, soft, nontender, without scars, and there were no palpable organs or abnormal masses. A fine tremor of the hands was noted. There was no peripheral edema, and the peripheral vessels were normal to palpation. Neurological examination revealed normally active and equal reflexes and no abnormal reflex was elicited. Careful rectal and pelvic examinations were entirely normal.

A routine voided urine specimen was normal except for 2+ albumin. A second specimen obtained at the end of the examination showed only a trace of albumin, and a third specimen collected the following day was negative for albumin. STS was negative. A complete blood count was normal, and a fasting blood sugar was 90 mg%. Chest x-ray and electrocardiogram were normal. The electrodes caused a rash to appear at the site of contact. No specific therapy was advised, and the dermatitis involving the fingers slowly healed completely.

In June, 1958, the patient developed a persistent cough which worsened at night. There was evidence of allergic rhinitis; when a cat was removed from the house, the cough quickly disappeared. During this time, the patient had all metal water pipes removed from her house and well. Plastic pipes were installed and the well was lined with tile. This was done by her husband at the suggestion of a friend who works with him at a nearby government installation.

Ankle swelling developed for the first time in April, 1959, upon the patient's return from a trip to California. The edema was extensive and extended up to the inguinal regions. Weakness and easy fatigability accompanied the swelling. At that time, her blood pressure was 120/80. Physical examination revealed no change except for the presence of a small cystlike lesion in the left breast. A rather large, movable mass was also found in the posterior cul-de-sac on pelvic examination. Urinalysis was normal.

The patient was referred to a gynecologist, and subsequently a laparotomy was performed. The mass was found to be an extremely large, pedunculated myoma. The entire uterus was removed together with the appendix. The adnexa was left undisturbed. Her postoperative course was uneventful. Routine laboratory findings during hospitalization were normal, and albuminuria was not observed in either of two urine specimens examined.

On August 19, 1959, the patient was seen again because of swelling of both lower extremities. She had no other complaints and felt well. Examination revealed enlargement of the liver and pitting edema of both ankles. Liver function tests were obtained, and the cephalin flocculation test was negative in 48 hours; BSP test, 2.5% retention of dye in 30 minutes; thymol turbidity was 4.5 units; total protein was 4.10 gm; albumin was 1.99, and globulin 2.11. Sedimentation rate was 40 mm/hr (Westergren); lupus erythematosus prep was negative. Urinalysis showed 4+ protein. A tentative diagnosis of nephrotic syndrome was made, and hospitalization was recommended for further evaluation.

The patient's husband requested that she be referred to the National Institutes of Health. On October 7, 1959, she was admitted to this institution and was discharged on November 16.

Following is a summary of laboratory data obtained while at the National Institutes of Health: hemoglobin 14.2 gm; RBC 4.9 million; hematocrit 44%; platelets 189,000; reticulocytes 0.4%; WBC 7,400; differential 48% mature polymorphonuclear leukocytes; lymphocytes 42%; monocytes 2%; eosinophils 8%; sedimentation rate 27; red cell indices: MCV 88, MCH 29, MCHC 33. Urinalysis: specific gravity 1.007; pH 6; Protein 2+; sugar negative; urinary sediment revealed a few red blood cells, a rare white blood cell, and rare hyaline casts. No doubly re-



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fractile bodies were seen. Total urinary protein for a 24 hour period was 10.3 gm. Repeated examination of the urine revealed essentially the same values. VDRL was nonreactive; protein bound iodine 5.1 μg%; PSP test 41% excretion in 15 minutes and a total of 61% in two hours; BMR +3; LE prep, negative; bentonite flocculation test for rheumatoid arthritis, negative; bentonite flocculation test for lupus erythematous, negative. Total cholesterol was 463 mg%; total protein 4.6%; albumin 1.4; globulin 3.2; thymol turbidity 4 units; cephalin flocculation test 2+ at 24 hours; Van den Bergh 0.2 total, 0.02 direct; SGOT 13 units; fasting blood sugar 80 mg%; creatinine 0.6 mg; serum electrolytes, normal. Serum electrophoresis revealed a high alpha 2 globulin and high gamma globulin and low albumin. An Addis count revealed 500,000 casts; white blood cells 1,010,000; red blood cells 20,795,000. Stool: negative for occult blood, ova, and parasites. A voided urine culture revealed hemolytic Staph albus; coagulase, negative; diphtheroids and a colony count, 100/cc; prothrombin determination, normal; BSP was 1% residual in 45 minutes.

Electrocardiogram and chest x-ray were normal. A flat film of the abdomen showed an enlarged liver shadow and a large biliary calculus. Both hands and wrists appeared normal. Skull films were negative. The cervical spines appeared normal. An intravenous pyelogram showed generous sized kidneys with the right being slightly larger than the left; there were no deformities of the calyces.

Skin and muscle biopsy specimens were normal. A renal biopsy was performed on October 22, 1959. The specimen contained only four or five normal appearing glomeruli, and the sections were considered inadequate. The patient has persistently refused to submit to another renal biopsy.

After hospitalization, the patient was started on hydrochlorothiazide 50 mg twice daily. The discharge diagnosis was nephrotic syndrome due to undetermined cause.

The patient was observed closely during the next four months. Hydrochlorothiazide was continued and edema was controlled. Repeated urinalyses continued to show 4+ albuminuria; serum potassium remained normal.

Therapy with steroids was started on February 1, 1960. Prednisone 60 mg daily was the initial dose, and a maintenance dose of 20 mg daily was given after diuresis. She responded to this form of therapy with an adequate diuresis of ten pounds and a decrease in proteinuria from more than 10 gm daily to 8 gm in 24 hours. Within three weeks, she developed symptoms of acute cholecystitis, and glycosuria appeared.

Examination revealed increase in the size of her liver and the presence of spider nevi on both arms. There was a good response to a low fat diet. Steroid therapy together with potassium chloride and hydrochlorothiazide were continued. A fasting blood sugar determination was 90 mg%.

Surgical consultation was indicated for the gall bladder disease and arrangements were made for admission to the Johns Hopkins Hospital. After a thorough workup, it was agreed that surgery was not indicated and that conservative, medical treatment should be continued.

Extensive laboratory investigations were again accomplished, but the results were the same as those obtained at the National Institutes of Health, except for the following: cholesterol 710 mg%; calcium 9.7 mg%, phosphorus 3.4 mg; alkaline phosphatase 4.6 units, total serum protein 5.8 gm; albumin 3.1 gm; globulin 2.1 gm; two hour p.c. glucose 78 mg%; Rose test: negative, ASO titre, 12 Todd units; PBI, 8.9 μg%; urea clearance showed 120% of normal in the first specimen and 85% of normal in the second specimen. Two quantitative 24 hour protein determinations were 5.1 and 4.6 gm/24 hours. Fishberg test showed a maximum concentration of 1.030; venous pressure was 90-100 mm of saline. A liver biopsy was performed and reported as normal.

The patient was discharged on prednisone 20 mg daily and was advised to continue a high protein, low fat diet. Antacids after meals and supplementary doses of potassium were also continued.

The consensus at the time of discharge was that the patient presented a picture of the nephrotic phase of glomerulonephritis.

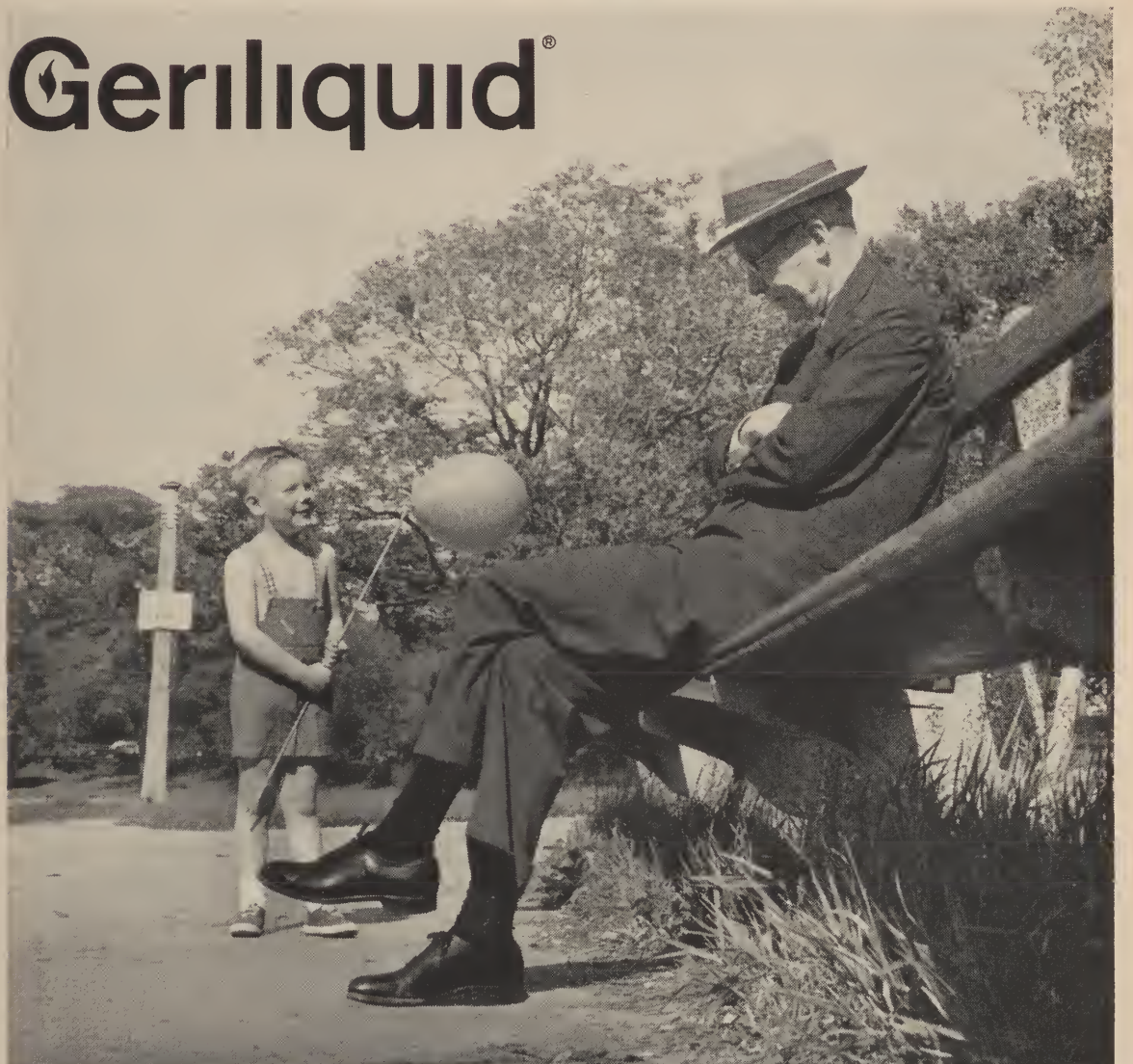
In June, 1960, she developed hirsutism, moon facies, and marked increase in her appetite. By choice, she had always followed a high protein diet. Now she had to eat every two or three hours and would get up several times during the night to eat a fairly large meal. Prednisone was decreased from 20 mg to 15 mg daily. At this time it was noticed that albuminuria exceeded 10 gm/24 hours. Sodium intake was kept at a mini-

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mum, and edema seemed fairly well controlled, but her weight would vary eight pounds in a 24-hour period.

In September, 1960, she complained of easy fatigability, nervousness, palpitations, sweating, backache, weakness in both legs after climbing steps, tremor, and still more increase in appetite, postprandial epigastric distress, and well localized epigastric tenderness. A gastrointestinal series showed no evidence of an ulcer and was considered normal. A cholecystogram showed a single, large, radiolucent calculus which appeared to move freely within the gall bladder with fairly good concentration of the dye. Urinalysis showed 4+ protein (15 gm daily); trace of sugar; specific gravity 1.010, and negative microscopic. Two hour postprandial glucose was 117 mg%; total serum protein 4.6 with albumin 2 and globulin 2.6; alkaline phosphatase 3.8 units; BUN 10 mg%; LE prep, negative; stool, negative for occult blood; chest x-ray, negative.

A full ulcer program was started. The patient was put on a 3000 calorie, low sodium, low fat diet. The prednisone was decreased to 15 mg daily. This regimen brought about relief of most of her gastrointestinal symptoms. She remained free of edema, but excessive proteinuria continued and signs and symptoms of hypermetabolism became more apparent. A BMR could not be done because the patient could not cooperatve by rest and fasting. She refused to go without food for more than two hours. A butanol extractable iodine determination was 3.5μg% and an ET_3 test was 16.4% (normal range 10.3-14.3).

The patient was then seen in consultation by an endocrinologist because of possible hyperthyroidism. A PBI was 8.1 μg% (a cholecystogram had been performed in September, 1960) and an RAI uptake was 18% in two hours (normal 6-12%) and 52% in 24 hours (normal 15-40%); serum cholesterol 970 mg%; total serum protein 4.0; albumin 1.9; globulin 2.1. The consultant did not think she had hyperthyroidism, and this opinion was confirmed after special tests were done on the patient's serum to determine the level of free thyroxine. The changes in her RAI uptake were thought to be secondary to her protein abnormalities. No treatment for hyperthyroidism has been given, and the patient continues to follow a diet in excess of 3000 calories daily. She is inactive and rests four to six hours daily. Prednisone 12.5 mg daily was continued with no change in the amount of proteinuria. The dose of corticosteroid was decreased to 10 mg in February, 1962, and to 7.5 mg in May, 1962. She has been maintained on this dose during the past year and there has been little change in her overall condition. Moderate glycosuria continues. A recent blood sugar was 120 mg%, two hours postprandial. More recently, episodes of gall bladder colic have occurred. Propantheline and antacids have been continued and have given symptomatic relief.

DISCUSSION

The introduction of percutaneous renal biopsy[1] and the use of the electron microscope[2] in the study of antemortem biopsy material have increased our understanding of the nephrotic syndrome. As a result of these studies, a more workable classification of the syndrome has been devised, and it has become apparent that it is not a single disease entity but the metabolic expression of a wide variety of underlying diseases.

Definitions of the syndrome are numerous, but all include the hallmarks of proteinuria, hypoalbuminuria, hypercholesterolemia, and edema. Berman and Schreiner[3] would use proteinuria in excess of 3.5 gm daily together with the presence of fat bodies in the urine as the *sine qua non* of the syndrome. In a more recent publication, Schreiner[4] has reviewed the subject of nephrosis thoroughly. His bibliography of 895 articles reveals the complexity of the subject matter. Only a few facets of the disease will be mentioned in this discussion.

In most of the series reported, intrinsic renal disease accounts for the largest number of cases. Many of the patients who showed "normal glomeruli" by light microscopy have been found by electron microscopy to have certain characteristic changes in the basement membrane and epithelial cell layer of the capillaries. The epithelial cell foot processes in the glomeruli of these patients appear to be uniformly smudged. The podocytes (epithelial cells) show loss of pedicles (foot processes) with replacement by an abnormal layer of cytoplasm. The basement membrane may be of variable thickness, and vents or gaps in this membrane have been described by Spiro,[5] who considers this the structural basis of proteinuria. Earle, Jennings, and Bernik[6] have not been able to observe these defects or holes which are said to permit diffusion of proteins. These defects in the basement membrane have been observed in cases

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ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

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of so-called pure lipoid nephrosis, membranous glomerulonephritis, and subacute and chronic glomerulonephritis.

It is interesting to speculate as to the changes that may be present in the basement membrane and podocytes of the "normal glomeruli" reported in the renal biopsy of the case under discussion. One recognized authority suggested that the patient is in the nephrotic phase of glomerulonephritis. A more precise diagnosis of membranous glomerulonephritis probably could have been made with the electron microscope. This points up the need to subject so-called negative renal biopsies to examination by the electron microscope in the case of the idiopathic nephrotic syndrome.

The patient's exquisite sensitivity to metals and other allergens, such as cat hair, calls to mind other causes of the nephrotic syndrome. Various toxic and allergic agents have been incriminated. Relatively recent reports mention organic mercurials, inorganic mercurials, tridione, paradione, bismuth, trichlorethylene, probenecid, perchlorate, and tolbutamide, as possible toxic causes. Poison oak, bee sting, and snake venom have also been reported as precipitating allergic factors.

Of the generalized disease processes associated with the condition, amyloidosis, both primary and secondary, systemic lupus erythematosis, multiple myeloma, and diabetic glomerulosclerosis have been reported. Raisz and coworkers,[7] with the help of percutaneous renal biopsy, have helped to clarify the place of amyloidosis in the spectrum of renal disease, particularly in the differential diagnosis of the nephrotic syndrome. Seventeen patients with amyloidosis were studied, and 10 were found to have the syndrome. Their course was that of rapid progression of renal failure. The rare case of clinical remission in this situation is invariably the result of treatment of reversible diseases such as tuberculosis, chronic suppurative processes, myxedema, and rheumatoid arthritis. Four of the five cases of primary amyloidosis in the series manifested themselves as the nephrotic syndrome.

In 1842, Rayer[8] first described seven cases of renal vein thrombosis, two of which were associated with the nephrotic syndrome. This association has been reported with increasing frequency. The renal vein thrombosis may be seen as a localized process, but it is usually associated with thrombosis or obstruction of the inferior vena cava. Morris, Ginn, and Thompson[9] described a case in an adult and emphasized the need for diagnostic inferior venacavogram in any patient with back pain and thromboembolism before closed renal biopsy is performed. They also found that the renal histologic picture of the syndrome in renal vein thrombosis is the same as that seen in membranous glomerulonephritis. Kowal, Figur, and Hitzig[10] used anticoagulants to treat a 53-year-old woman with this condition and were able to bring about a complete remission of the nephrotic syndrome.

Other mechanical causes of the nephrotic syndrome are constrictive pericarditis, congestive heart failure, and congenital heart disease. Pregnancy rarely coexists with the nephrotic syndrome. Silberman and Adams[11] state that the pregnancy may proceed successfully without altering the mode of management of either condition.

Various infections are known to be associated with the nephrotic syndrome; syphilis, malaria, subacute bacterial endocarditis, and tuberculosis have been reported. Robins and Ladd[12] recently published a case in which the nephrotic syndrome developed as an acute disorder during the secondary stage of syphilis. Scott and Clark[13] have described a patient with the syndrome which appeared after a Herxheimer reaction with penicillin therapy. Infectious mononucleosis may be complicated by the nephrotic syndrome. Greenspan[14] recently reported such a case, and the excessive proteinuria cleared completely after two courses of steroid therapy.

The onset of signs of the nephrotic syndrome may take place at or immediately after birth. Oliver[15] has suggested that the basic lesion in infantile nephrosis lies in the development of the nephron. Worthen[16] and his associates have shown that the disease may be familial. Electron microscopic examination of biopsy material from their patients revealed changes in the podocytes identical with those seen in the nephrotic syndrome in older patients.

This patient's clinical picture has suggested, from time to time, the possibility of hyperthyroidism. Her intake has consistently exceeded 3000 calories daily. She rests for long periods during the day and sleeps at least 10 hours each night but has failed to gain weight. Tachycardia, palpitation, hyperactivity, easy fatigability, fine tremor

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of tongue and fingers, excessive sweating, warm, moist palms, diarrhea, and slight but definite exophthalmos help to keep the impression of a hypermetabolic state constantly in mind. I cannot find a case of hyperthyroidism and the nephrotic syndrome reported in the literature. In fact, patients with the nephrotic syndrome usually have a low PBI and low BMR. One BMR determination early in the course of the disease was reported as 3+. Also, as in this case, the radioactive uptake may be normal to high.

The low PBI could, in part, be due to excessive renal loss of thyroxine. Recant and Riggs,[17] however, consider this loss insufficient to account for the low serum iodine concentration. They found that the thyroxine binding capacity of plasma proteins was low in nephrotics and that a normal supply of thyroxine was delivered to the peripheral tissues and degradation rates were normal. The low BMR could be explained by a severe body protein deficiency.

Rasmussen,[18] using I^{131} labeled thyroxin, found a lower than normal degradation rate and concluded that this could explain the low BMR in these patients. Robbins, Rall, and Petermann,[19] by studying nephrotic sera, have demonstrated that thyroxin interacts chiefly with an interalphaglobulin, designated TBP (thyroxin-binding protein), albumin, and a third protein. Ingbar[20] has recently described this third protein and called it TBPA (thyroxin-binding prealbumin). It is said to have four times the thyroxin-binding capacity of TBP. Both TBP and TBPA are reduced in most nephrotic patients, which could account for the low PBI.

Since nephrotic patients are invariably euthyroid in the presence of a low PBI and low BMR, it is difficult to correlate the existence of hyperthyroidism except that the thyroid gland may conceivably become hyperactive in order to compensate for the continuous loss of hormone in the urine.

In 1950, Barness, Moll, and Janeway[21] listed 64 different lines of treatment used for the nephrotic syndrome between 1926 and 1948. Shortly thereafter, Farnsworth[22] reported 14 cases of the syndrome which had been treated with ACTH. She observed that children responded to the hormone much better than adults, and two children had complete remissions.

Nitrogen mustard and ACTH have been used with beneficial effects in lipoid nephrosis. Nitrogen mustard alone in treating children with the nephrotic syndrome has given poor results. Combined steroid and nitrogen mustard therapy has been used in 10 patients by Talamo and Crawford.[23] Six showed a favorable response. A small group of patients with idiopathic nephrotic syndrome has been treated with 6-thioquanine. The antimetabolite lowered gamma-globulin levels; interruption of an autoimmune process was postulated.

The patient reported has shown little or no real response to steroid therapy. Fishberg[24] has seen few recoveries from the nephrotic syndrome in adults and never in a patient above the age of 40.

Ross and Smith[25] recently attempted to assess the effectiveness of steroids in the treatment of the nephrotic syndrome. They conclude that no specific therapy is available. The usual therapeutic approach is to render the patient free of edema with diuretics, aldosterone antagonists, or cation-exchange resins and then attempt the abolition of proteinuria with glucocorticoids. They treated 26 patients with this regimen; five became entirely free of proteinuria, while six responded with a reduction of proteinuria to less than one gm/liter, and the remaining 15 showed no response. Nesson and coworkers[26] had similar results. Twenty per cent of 42 adult patients had complete remission of proteinuria on steroid therapy, 52% of the remaining patients showed no response, while 14% went on to have a spontaneous cure after showing no decrease in proteinuria while on corticosteroids. It is encouraging to note that failure to respond promptly to steroids did not preclude the possibility of later spontaneous remission. It is hoped that this may occur to the patient who is the subject of this report.

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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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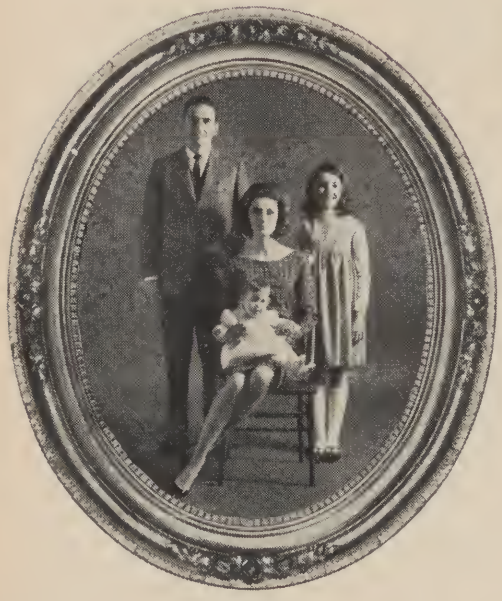
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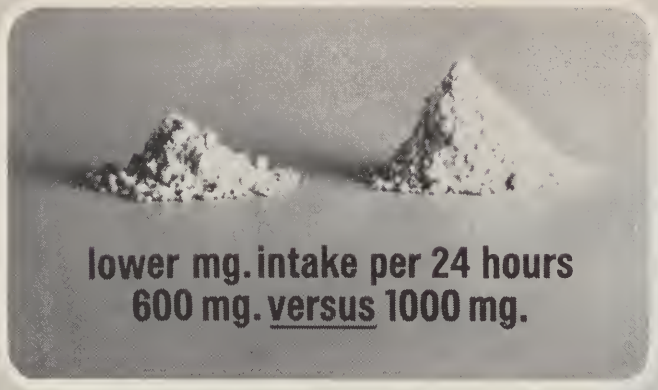
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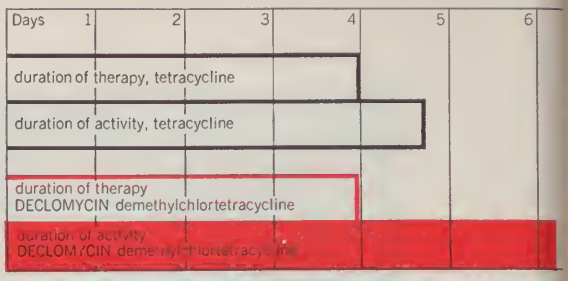
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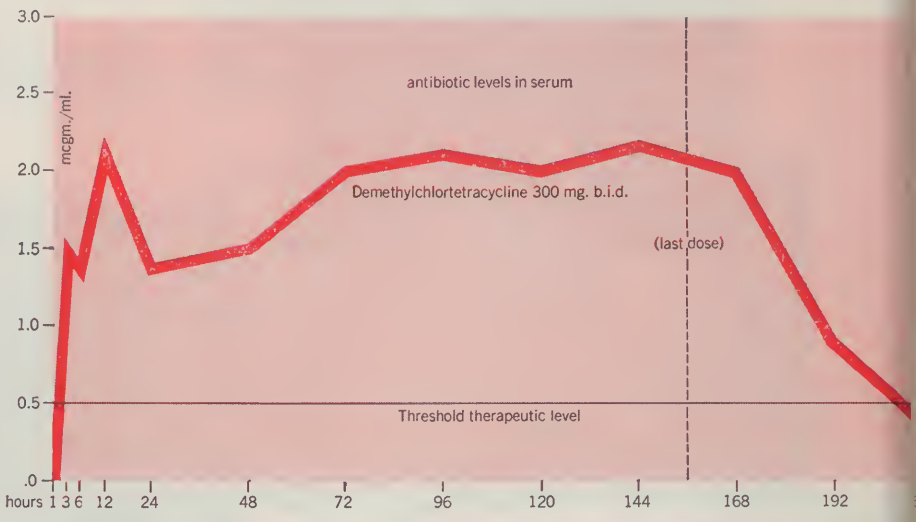


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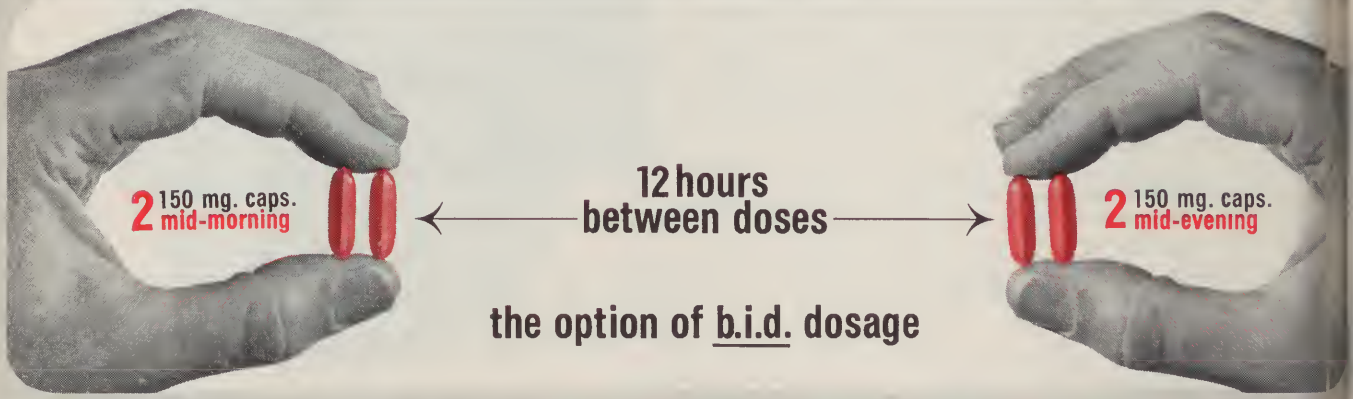


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Urine Specific Gravity and Renal Function

ROBERT J. FURIE, MD

The determination of urine specific gravity is a fine means of assessing renal function. Though simple to perform and requiring simple preparation, the measurement of urinary specific gravity remains one of the best tests available to the physician in need of analyzing the renal function of a patient.

There is merit in examining the situation which makes urinary specific gravity so valuable a procedure. The urine collected from the bladder represents a product which has undergone many alterations in the course of production.

Initially, the circulating blood (approximately 450 gallons of blood pass through the kidneys each day) traverses the glomeruli, which form about one square yard of filter surface.

Obviously, the numerous factors concerned with an adequate filtration pressure must be in order to insure the formation of filtrate. The pressure relationships of arterial pressure, osmotic pressure, capsular pressure, renal interstitial pressure, and intratubular pressure must be properly maintained, not to mention the anatomic integrity of the glomeruli.

Assuming that all the glomerular features are operative, the filtrate which forms will total some 45 gallons each day. At this stage, the filtrate will have about the same specific gravity as plasma, or about 1.007 or 1.008. Lying ahead for this glomerular filtrate are about one and a half to two million tubules which aggregate a linear measurement of about 40 miles.

The proximal convoluted tubules will avidly re-

The specific gravity urine concentration test has a leading position in the tests available for assessment of renal function. Informative, inexpensive, and uncomplicated, it can be recommended highly in all phases of the practice of medicine. Only in the small percentage of patients who cannot concentrate to 1.025 do other renal function tests become important.

absorb many essential metabolites and water and secrete some others.

In the descending loop of Henle, there is passage of water from the tubular lumen into the interstices without loss of sodium; while at the loop and ascending limb of Henle, there is a selective transfer of sodium from the tubule to the interstices.

As the urine proceeds to the distal convoluted tubules, the specific gravity is low (below 1.007-1.008). This state of affairs presents a dilute urine to the distal and collecting tubules and leaves the final decision on the production of a concentrated or dilute urine up to the posterior pituitary gland and antidiuretic hormone (ADH).

If there is need for water in the body metabolism, the ADH causes tubular reabsorption of water in the distal and collecting tubules. In this manner, a urine with high specific gravity is produced. The converse is true when water is not needed and ADH fails to act on the tubules, thus causing water loss and a dilute urine.

A moment's reflection of the great number of features which must be operative in order to produce a concentrated urine will explain the good correlation between the test and the results from more complicated and sophisticated tests.

In an analysis of 5,000 urine concentration tests performed before excretory urography, about 86% had urinary specific gravity measurements of 1.025 or higher. The specific gravity was measured after fluids were withheld for 16 to 18 hours. Invariably, patients manifesting a urinary specific gravity of 1.025 or higher had normal renal function when evaluated by endogenous creatinine clearances, PSP excretion tests, or intravenous urograms.



This reliable test has been traditionally performed with a hydrometer. Yet, through faulty equipment or faulty technique, the results have not always been reliable. When hydrometers are used to measure urine specific gravity, they should be calibrated. At a temperature of 16° C (60° F), distilled water should give a reading of 1.000; 0.85% (W/V) sodium chloride solution should read 1.006; and 5% (W/V) sodium chloride should give a reading of 1.035. The calibration should be performed at these three points to insure the accuracy of the hydrometers over the entire range of readings.

A correction should be made in hydrometer readings for temperature. For each three degrees above 16° C, .001 unit should be added to the observed measurement. That this feature cannot be ignored is readily apparent when a reading of a urine at body temperature (freshly voided specimen) of 37° C is compared with a reading at 16° C. One must add .007 units (37° C — 16° C = 21° divided by 3 = 7 units) to the observed value at 37° C to make it comparable to the reading at 16° C. Thus a reading of 1.018 at 37° C represents a true value of 1.025 at 16° C.

Other corrections that are necessary are those referable to proteinuria and glycosuria. In the presence of 1% glucose in the urine, .004 units should be subtracted from the observed hydrometer value. When proteinuria is present, a subtraction of .003 units is necessary for each 1% of protein.

Care must be taken not to perform the specific gravity-urine concentration test while the patient is in the process of eliminating high-density contrast medium used in urography. The presence of these contrast substances may raise the urine specific gravity to 1.070 for several hours after the excretory urogram.

A relatively inexpensive instrument is available for the determination of urine specific gravity which obviates many of the problems presented by the hydrometer. The hand refractometer, or T-S Meter, permits the performance of urine specific gravity with variations of .001 unit. Since the instrument is temperature compensated, no correction for temperature need be made. Since only two drops of urine are necessary, this determination can be performed on urine specimens of small volume.

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A case of renal medullary necrosis is reported. This case represents some characteristic features of the disease.

Renal Medullary Necrosis

RICHARD C. REYNOLDS, MD

Renal medullary necrosis, as the name implies, is an ischemic necrosis of the medulla of the kidney. Infection of the ischemic portion of the kidney occurs, and clinically the course of illness resembles a malignant pyelonephritis with rapidly diminishing renal functions, oliguria, and uremia. It is commonest in the elderly, the diabetic, individuals with obstructive uropathy, and sometimes is associated with the chronic use of analgesics. Necrotizing papillitis, necrotizing pyelonephritis, and renal papillary necrosis are other names used to describe this disease. Formerly a pathologic diagnosis only, this condition can now be recognized antemortem by means of judicious use of renal biopsies and retrograde pyelography. Early diagnosis is important, as improved antibiotics for gram negative infection has made possible the successful treatment of renal medullary necrosis.

The following case history represents the first description of renal medullary necrosis in a patient from Frederick Memorial Hospital.

An 80-year-old white woman was admitted to the urological service because of gross hematuria of three weeks duration. Other urinary symptoms were urgency, frequency, and dysuria. Cystoscopic examination performed the day before admission revealed a large clot in the bladder and the suggestion of a bladder tumor. The patient had had vague, generalized abdominal pain for 20 years. Numerous x-ray studies of gastrointestinal tract were normal. The symptoms did not respond to antacids, antispasmodics, or sedation. The patient consumed large quantities of non-narcotic analgesics, but it was impossible to estimate the quantity. At times psychiatric hospitalization for eight month intervals was necessary with brief remissions in her hypochondriasis. The uterus and gall bladder had been removed several decades previously.

Physical examination at time of admission revealed an elderly, senile lady with no evidence of weight loss. Blood pressure was 200/100. Cataract operations had been performed on both eyes. No nodes were palpable. Lungs were clear. Heart was normal in size with regular rhythm and no murmurs. The abdomen was soft. No organs, masses, or tenderness was noted. Pelvic examination revealed a senile vaginitis and clean cervix. All peripheral pulsations were present, but the vessel walls were thickened and sclerotic.

Two days after admission, cystoscopic examination demonstrated a large bladder tumor occluding the left ureteral orifice. The tumor was partially resected transurethrally. On pathologic section, the tumor was reported as a squamous cell car-

cinoma. After surgery the hemoglobin fell to 9.0 gm. Two days after surgery, the patient was given a blood transfusion. After receiving 250 cc of whole blood, she had a grand mal seizure and mental confusion for the following 12 hours, and her temperature rose to 103.2° F.

Serum urea nitrogen on admission was 15 mg%. The day after the transfusion reaction it had risen to 40 mg%. Urine cultures obtained before surgery and again from bladder urine during surgery were negative. Two days after the transfusion, pseudomonas was isolated from the urine in excess of 100,000 colonies per milliliter of urine and was resistant to all antibiotics.

Unfortunately the bladder irrigating fluids confused the measurement of urine output, but at no time was it greater than 200 cc a day. For the next 14 days after the transfusion, the patient remained oliguric. She received 500 mg of chloramphenicol daily. Careful fluid balance was maintained. She did not go into heart failure. She remained alert until three days before death. The temperature did not go higher than 100.2° F. Her serum urea nitrogen rose to 158 mg%, and the serum potassium to 5.8 mEq/l 48 hours before death. There was no inclination to diuresis at any time, and she died on the fourteenth day of oliguria.

Two different reference laboratories recognized an Anti-Kell antibody in the patient's serum compatible with the transfusion reaction. The most striking pathologic lesion was "suppurative exudate infiltrating the renal parenchyma and extending from the medullary portion to the cortex. There is also a necrotizing papillitis in which there appears to be infarction necrosis and suppuration of the pyramids." There was no pathologic evidence in the kidney sections of a transfusion reaction.

Some important features of renal medullary necrosis are described in this history. The patient was elderly and arteriosclerotic. She had a bladder carcinoma that required surgery and instrumentation of the urinary tract. The bleeding from the lesion initially and after surgery caused anemia, increasing the ischemia of the kidney. Infection of urinary tract followed instrumentation and undoubtedly precipitated the illness responsible for the patient's death. The patient had a transfusion reaction which resulted in oliguria and helped to compromise further the circulation of the kidney. At autopsy, however, the kidney showed only rampant infection and necrosis of the medullary portion without any anatomic evidence of renal damage from the transfusion reaction. The initial oliguria may well have been caused by the transfusion reaction, but its persistence and the death of the patient in uremia is attributable to the infection and necrosis of the renal medulla.

The patient was a long time user of over-the-counter analgesics. Phenacetin, when ingested in large doses for long periods, has been reported to be nephrotoxic and to cause an interstitial nephritis.[1] Renal medullary necrosis has also been seen in heavy users of phenacetin either alone or in combination with the interstitial nephritis.[2] A 25% incidence of necrosis of renal papillae has been described at autopsy in patients with rheumatoid arthritis and indirectly related to the frequent and prolonged use of analgesics encouraged by this illness.[3] There appears to be a direct relationship between the amount of drug consumed and the incidence of renal damage. If ten APC tablets are taken every day for 14 years, approximately 75% of the patients will show a decrease in renal function.[4] Whether the kidney dysfunction is the result of phenacetin or the other drugs with which it frequently is combined is still unknown, but there appears to be an increased incidence of kidney damage, including renal medullary necrosis, associated with long term use of analgesics containing phenacetin.

Recently an excellent review of renal medullary necrosis by Lauler et al has summarized the clinical features of 250 cases which have been reported in the literature until 1960.[5] Fifty-four per cent of these patients were over 60, but 90% were over 40 years of age. Twice as many patients were women. Diabetes was present in 57% and almost invariably was poorly controlled. Most patients were seen initially for urinary tract sepsis. Sixty-four per cent of the deaths were attributable to uremia. Catheterization and obstructive uropathy were common among the patients studied. Diagnosis before death was established in 13% of the cases. Only 18 of the 250 patients survived.

The greatest aid to diagnosis is an awareness of the illness and a familiarity with the clinical setting in which it occurs. Any fulminating urinary tract infection occurring in an elderly person, frequently a diabetic, and usually associated with rapidly diminishing urinary output, strongly suggests

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the possibility of renal medullary necrosis. A history of urinary tract instrumentation is common, along with lesions causing urinary tract obstruction. Diabetes, when present, is poorly controlled. Frequently the features of gram negative bacterial sepsis will overshadow the other aspects of the illness. The patient may experience ureteral colic as the necrotic papillae are sloughed and attempt to pass through the ureter.

Conclusive diagnosis is established by the recovery of necrotic papillae in urine. This is accomplished by straining the urine in the same manner one looks for a kidney stone. The discarded papillae are easily recognized under the microscope. Renal biopsy, which may be indicated if the cause of renal failure is obscure, will give proof of diagnosis. Pyelography gives suggestive evidence of renal medullary necrosis, as the destruction of the papillae results in a haziness and sinus tract formation in the region of the papillae, giving rise to a characteristic "ring" shadow.

Treatment is directed at the infection and any associated illness. Urine culture with drug sensitivities of the infecting bacterium are imperative in order to select the proper antibiotic. Bactericidal drugs such as colistin, cephalothin, and kanamycin should be used preferably over bacteriostatic drugs. Frequently more than one microorganism will be cultured from the urine. Quantitative bacteriology will help to separate the pathogens from the contaminants. A positive blood culture will frequently identify the pathogen responsible for the sepsis, originating from the urinary tract infection. Urinary obstruction must be relieved, diabetes controlled, and adequate hydration and urine output maintained.

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Frederick, Md

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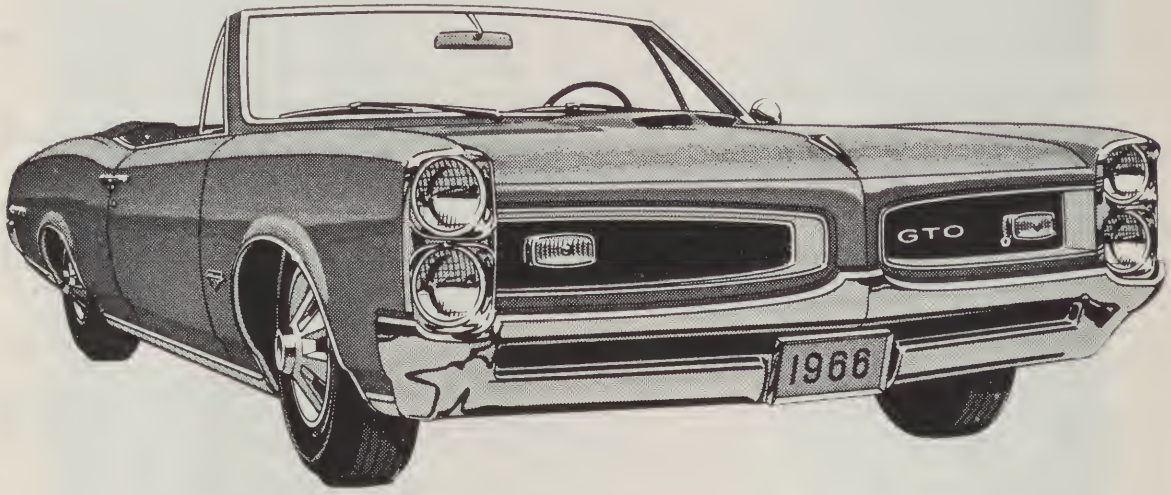
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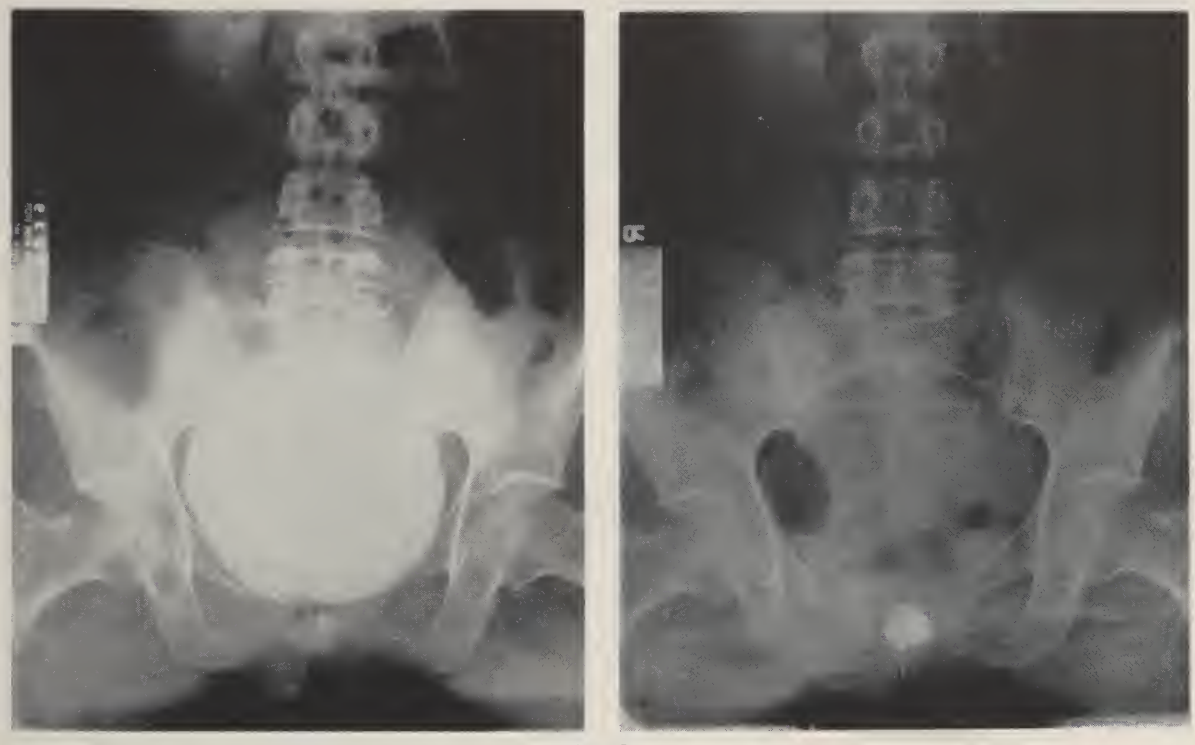


Fig 1
Female urethral diverticulum

Urological Aspects of Urinary Tract Infections

The presence of acute infections in the urinary tract should be determined and adequately treated. Prompt institution of chemotherapy or corrective surgical procedures should prevent a subsequent incurable or chronic condition.

ROBERT D. CROUCH, MD

Infections of the genitourinary tract have attracted unusual interest in recent years, especially in the field of pediatrics and the etiology of pyelonephritis. Since acute infections are curable, prevention of chronic infections is our main objective. In this day and age of chemotherapy and corrective surgical procedures, there is little excuse for allowing infections to become incurable or chronic. I happen to be one who believes it is difficult to infect a normal urinary tract; just because we cannot demonstrate abnormality does not mean it doesn't exist. Cineradiography has certainly emphasized this fact.

The most common pathogens are gram negative bacteria, mainly *Escherichia coli, Aerobacter aerogenes, Proteus vulgaris,* and *Pseudomonas aeruginoma.* These are usually single but may be in combination in chronic infections.

There is increasing evidence that ascending infection is the most common cause of urinary tract infection. This disease is common from birth to the age of 12, 80% of cases occurring in girls. New infections are seldom seen between the ages of 12 and 20; then it becomes common again, mostly involving women and paralleling the years of sexual activity. After age 60, infec-



Fig 2
Bilateral hydroureteronephrosis due to ureterovesical dysfunction



Fig 3
Postoperative correction of the ureterovesical junction shown in fig 2

tion again increases in incidence, but mostly in men because of bladder neck obstruction. All of this indicates that infections travel up the urethra.

Urethral meatal strictures, with or without hypospadia, are most common and are easily treatable. Other types also cause infection proximal to that point, especially in children. The female urethra was once considered to be just a tube and had little significance. Now we know that this "insignificant" structure can cause a great deal of morbidity and even uremia and death when obstructed. I believe in the near future urethral dilatation or calibration in newborn girls will be done as frequently in the nursery as circumcision is done on boys. I am convinced that this would eliminate many subsequent infections and obviate the need for future urologic surgery.

Urethral diverticula should be considered, especially in a woman who has repeated bouts of infections or in cases that are difficult to eradicate when the usual studies and evaluations are otherwise normal. Figure 1 illustrates such a case. This 50-year-old white woman had been treated for many weeks with various chemotherapeutic agents without benefit. Cystourethrogram and urethroscopy revealed a diverticulum. Surgical excision allowed rapid sterilization of the urine.

Contracted bladder necks are a common cause of residual urine and consequent infection in all ages. In young females, urethral stenosis or strictures are much more common, and most urologists now regard conservative treatment of periodic urethral dilatations with chemotherapy as the treatment of choice. This must depend on the patient's response and course. Vesico-ureteral reflux with progressive damage to the upper tract would require surgical intervention. Revision of the bladder neck or one of the reflux procedures of the ureterovesical junction may be necessary.

Infections of the bladder are by far the most common of the genitourinary tract. Cystitis in women is usually due to ascending infection of the short urethra. Attacks are so commonly related to sexual intercourse that some physicians are advocating prophylactic chemotherapy. Infection usually develops 36 to 48 hours after coitus. There may already be some abnormality, such as urethral stenosis or infected periurethral glands. Experimental evidence suggests that a normal bladder is difficult to infect.

Cystitis in men occurs secondary to inflamma-

tion of the kidneys or prostate or to the presence of residual urine from bladder neck obstruction. Prostatic hypertrophy with residual urine and development of calculi or bladder diverticula leads to chronic urosepsis, and complete cure becomes progressively difficult.

Chronic cystitis may be due to chronic pyelonephritis. Too often it is the result of incomplete treatment of a simple, acute cystitis.

In women, symptoms of cystitis and those of urethritis and trigonitis are often similar. A voided specimen for urinalysis or even a clean voided culture may not be enough.

Several years ago I treated a woman who supposedly had recurrent urinary tract infections. She was a military dependent and had received hundreds of dollars worth of antibiotics over a period of several years for positive cultures of "clean caught specimens." I studied this patient for over a year with numerous cultures which I collected and never once obtained a positive culture. She had urethrotrigonitis and did not require antibiotics or chemotherapy.

Isolated infections of the ureter do not occur but are secondary to other infections of the genitourinary tract. We are all familiar with the infections that follow experimental obstruction of one ureter. There are many ureteral diseases that predispose to pyelonephritis, such as vesico-ureteral reflux, ureterovesical stricture, ureteropelvic obstruction, calculi, tumor, or extrinsic obstruction.

Figure 2 demonstrates huge bilateral hydroureteronephrosis due to ureterovesical dysfunction in a 4-year-old boy after an acute urinary tract infection. The infection alone led to discovery of this condition, even though this child had been cared for since birth by skilled pediatricians.

Figure 3 shows postoperative surgical correction of the ureterovesical junction. This boy has been free of infection for nearly two years.

Abnormalities of the ureterovesical junction may be neuromuscular, congenital or acquired strictures, or damage from recurrent infections, with or without obstruction in the urethra or bladder neck. Many of these conditions result in vesico-ureteral reflux.

Congenital ureteropelvic obstructions are common. These are frequently discovered because of infections and resulting symptoms. Ideally, this correctable condition should be found before se-



Fig 4
Flat plate of abdomen showing huge bilateral renal calculi due to congenital ureteropelvic obstruction



Fig 5
Postoperative film following nephrolithotomy of patient in fig 4

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vere renal damage has occurred, but figures 4 and 5 show the pre- and postoperative film of an unusual case. This 32-year-old man was found to have bilateral ureteropelvic obstruction at the time of an acute infection at age 14. Surgical division of bilateral aberrant vessels was done. Infection continued, and small bilateral calculi were found three years later. The patient did not see a physician for 10 years, at which time the preoperative film shown here was taken. He subsequently underwent bilateral nephrolithotomy at two procedures, and the postoperative film is shown with the removal of all calculi. This patient is now healthy and active with bilateral nephrostomies. Because of the marked degree of chronic pyelonephritis and hydronephrosis, nephrostomy tubes are necessary for irrigation and to prevent calculi. Simple division of aberrant vessels is not enough; frequently an underlying intrinsic stricture also requires surgical repair. This patient demonstrates that frequently treatment is possible even when the situation appears hopeless.

Recurrent renal calculi occasionally lead to pyelonephritis, but they are more often secondary to the infection.

Hematogenous infections develop in the renal cortex and usually spread to the medulla and down the ureter, the opposite of the more frequent ascending infections.

Management should be directed toward three main steps: First, establish definitely that urinary tract infection exists. Cultures may not always be necessary in lower tract infections, but the organisms should always be identified in pyelonephritis. Second, establish the presence or absence of obstructive uropathy and correction of the condition. This can usually be done with the routine urologic procedure. Again let me emphasize that failure to demonstrate minimal obstruction does not mean it doesn't exist, especially in the lower tract and specifically in the urethra, bladder neck, and ureterovesical area. Third, treat the infecting organism with appropriate chemotherapy and treat it adequately, longer than necessary if there is any doubt. There are far more patients with serious consequences from inadequate treatment than from untoward reactions to chemotherapeutic agents.

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Special Techniques of Intravenous Urography

A review of radiographic procedures for visualizing the urinary system.

The excellent visualization of the urinary system obtained after angiographic procedures and the lack of significant increase in morbidity or mortality after the intravascular injection of high volumes and high concentrations of organic iodides has led to attempts to evaluate the usefulness of high doses of contrast substance for routine intravenous urography and to the development of several techniques of nephrography which have extended the capabilities of radiologic diagnosis of urinary tract lesions.

When we speak of using high volumes of iodides on a routine basis for urography, the first question which comes to mind is, "How safe is it?" As practicing physicians and members of the medical section, you are familiar with the side effects and reactions which can occur after the intravenous injection of organic iodides. Before considering the radiologic aspects of intravenous urography, let's review some of the current thinking regarding the toxicity of contrast substances, the incidence, prevention, and treatment of which has been extensively written about. Untoward effects may be expected in approximately 10% of patients. These will vary from what may be properly termed side effects, such as nausea, vomiting, a sensation of warmth, or flushing to true allergic reactions, such as urticaria, precipitation of an asthmatic attack, or vasomotor phenomenon characterized by chills, diaphoresis, and hypotension to the point of a vasomotor collapse. The incidence of severe reactions of this type is so low that the practicing radiologist may never see one.

Probably the largest amount of data regarding the incidence of fatal reactions to intravenous urographic contrast substances has been accumulated and reported by Pendergrass and associates[13] covering the years 1942-1952 and 1953-1956. They found a relatively constant rate of fatal reactions through this entire period of time, averaging 8.6 deaths per million urographic examinations. How many of these deaths could have been prevented by prompt and proper therapeutic measures is a matter for conjecture.

From the Department of Radiology, Frederick Memorial Hospital.

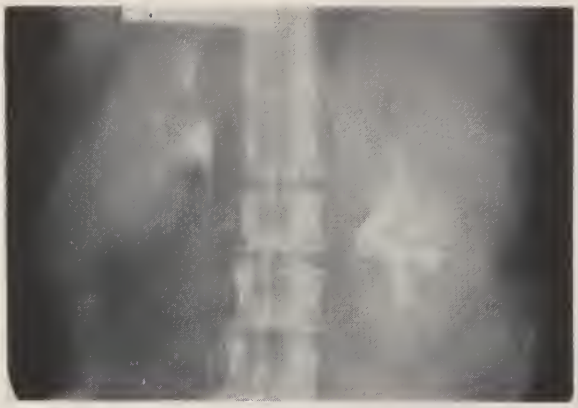


Fig 1
Left hypernephroma, Female, Age 45. Late nephrographic phase showing what appears to be a "tumor stain" in mid-portion of the mass extending from the upper pole of the left kidney.

It has been conclusively proven[7, 13] that there is no method of testing for sensitivity which is of any value. The difficulty in interpretation and unreliability of conjunctival, intradermal, or sublingual testing is well established. Similarly, with regard to the intravenous test, cases have been reported where patients did not react to a test dose of 1cc but did react to the full dose given 20-30 minutes later. On the other hand, profound and immediate reactions can occur with the injection of a fraction of a cubic centimeter. Despite the proven unreliability of the intravenous test dose, most physicians, for medical-legal reasons, will inject 1cc intravenously and wait one to five minutes before giving the rest. The minor side effects such as nausea, vomiting, or flushing do not contraindicate injection of the full volume of contrast substance, nor do they contraindicate repeated injections when necessary.

The prophylactic use of antihistamines has been proposed,[5] but its value has been questioned.[7] The preponderance of opinion at this time is that antihistamines are of no value in preventing serious reactions and should be reserved for therapeutic use in urticarial reactions. It has been suggested that one possible beneficial effect of a prophylactic antihistamine is the feeling of reassurance and confidence which it gives the physician. There is probably more truth than one would suspect in this statement, for I firmly believe that many of the minor side effects attributed to intravenous contrast substances and, for that matter, much of the discomfort associated with the barium enema examination, can be traced to the patient's anxiety which is often enhanced by the physician's attitude. It is surprising how much effect the physician can exert by the simple expedient of proper semantics. Avoiding the use of such terms as "needle" or "injection" and the classical warnings, "This will hurt a little bit," or, "You may feel nauseated," which act as suggestions which many patients are happy to accept, will greatly reduce the incidence of so-called side effects. With the patient non-apprehensive and relaxed, an examination of better diagnostic quality is often achieved.

E. F. Bernstein et al[3] have published data concerning the toxicity of sodium diatrizoate (Hypaque) 90% in dogs following rapid intravenous injection within five seconds. They found that in doses titrated between 1 to 6cc/kg body weight, the LD 50 was 3cc/kg and the LD 100, 5cc/kg. In those animals which died, death generally occurred within one minute of injection and was characterized by acute hypotension and electrocardiographic abnormalities which showed an initial rapid tachycardia followed by severe bradycardia with ischemic ST-T wave changes. The LD 50 dose of 3cc/kg is equivalent to 2700mg/kg of Hypaque-90. Studies by Hoppe[9, 10] established a LD 50 dose of 13,200mg/kg of Hypaque, but this was administered by intravenous drip at a rate of 12cc/minute. Bernstein concluded that the marked decrease in the LD 50 dose in his experiment was directly related to the rapid injection.

Read[15] has shown that there is erythrocyte agglutination after intravenous administration of hypertonic solutions, including sodium diatrizoate. This theory of erythrocyte sludging as a basis for the fatal reactions to intravenous contrast substance has been generally accepted, and the use of dextran in the prevention of same has been reported and accepted clinically.

In a second publication,[2] Bernstein and coworkers report that the LD 50 and LD 100 dose is approximately doubled in dogs by premedication with dextran. They also report a series of 21 patients who were given an average dose of 1.39cc/kg of 90% sodium diatrizoate for venous aortography after premedication with 15% dextran in 5% dextrose, given in a dosage of 10cc/kg. No mortality or serious complication occurred. Although dextran was proved to be the best premedication in the dog experiments, Bern-

stein also showed that the LD 50 dose of Hypaque-90 was increased by hydration of the animals with 5% dextrose or normal saline. In a routine angiocardiographic study, a patient may receive as much as 3cc/kg of 70% sodium diatrizoate. O'Connor aand Neuhauser[12] have used 3-4cc/kg of 50% sodium diatrizoate in infants to achieve what they term "total body opacification."

Since high volumes and concentrations of the modern tri-iodinated contrast substances can be given with as much safety as the 20-30cc dose used in conventional intravenous urography, is there any advantage to be gained by the use of high volumes of contrast substance routinely? Friedenberg and Carlin[8] compared the diagnostic quality of intravenous urograms using the standard 30cc dose of 50% sodium diatrizoate with a second examination on the same patient employing a dose based on the body surface area and ranging from about 30cc in an 87-pound, 1.30 square meter area patient to 80cc in a 202-pound, 2.12 square meter patient. They classified each examination as *excellent, good, fair,* or *poor* and found that the frequency of excellent or good examinations was increased from about 65% with the standard dose to about 95% with the high volume technique. They cite the following advantages of the high volume method: 1) urograms of diagnostic quality in larger patients are more easily obtainable; 2) the more intense nephrographic effect allows the diagnosis of parenchymal lesions often not visualized otherwise; 3) the ureters are more completely filled, which is important in determining displacement due to extrinsic abnormalities; 4) the bladder is better opacified, especially after one hour, and voiding urethrograms can be obtained. They also point out that the technique is of value in producing diagnostic urograms in the presence of renal insufficiency.

Thirty-eight of the 570 patients in the series had elevated blood urea nitrogen levels ranging from 22 to 92mg/100cc, with 17 having levels above 30mg/100cc. The quality of the urograms obtained in these patients was excellent in 11, good in 9, fair in 10, and poor in 8. Thus, excellent or good studies were obtained in more than half of the patients with renal insufficiency. More side effects occurred in the patients receiving high volumes of contrast substance, but these were minimal. The incidence of nausea increased from 7 to 13%; vomiting from 5 to 6% urticaria occurred in 1.5 and 1.4% of the standard and high volume studies respectively.

One of the advantages of the high volume technique is the nephrographic effect produced in a higher percentage of patients. The nephrogram refers to the opacification of the renal parenchyma as the contrast substance passes through the arterial system and is filtered through the glomeruli. If the renal parenchyma is sufficiently opacified, absence of normal parenchymal tissue or areas of decreased vascular supply can be demonstrated, especially if tomography is performed during this phase. Thus, the nephrogram or nephrotomogram can be an important diagnostic tool in differentiating between a benign renal cyst or a carcinoma. A renal cyst will be demonstrated as a radiolucency and, if it is large enough, will usually cause extrinsic pressure on portions of the collecting system. A tumor mass will show a normal opacification indistinguishable from the rest of the renal parenchyma or possibly an increased opacification; delayed films may show residual staining in the area due to retention of contrast substance in the vascular bed of the tumor (fig 1).

One possible source of error in differentiating between a renal cyst and a neoplasm occurs when there is a well circumscribed tumor which has undergone central necrosis, since both lesions will be demonstrated as an area of radiolucency on the nephrogram. Bosniak and Faegenburg[4] have recently described a diagnostic sign which will help to avoid some of the pitfalls in diagnosing necrotic renal tumors. They have observed that the walls of a true benign renal cyst are seldom visualized and, when they are, they appear as a thin line of about the thickness of a sharp pencil line. A necrotic renal carcinoma, on the other hand, will show the radiolucent center of a renal cyst, but the walls will be demonstrable and often will be irregular in thickness.

Evans,[6] in 1957, was one of the first to devise a technique of nephrotomography and to demonstrate its value in the differential diagnosis of space-occupying lesions of the renal parenchyma. With his method, the patient is first given a 30cc dose of 50% sodium diatrizoate intravenously, which acts as a "loading" dose to the renal parenchyma and enables identification of the collecting systems. The arm-to-tongue circulation time or the arm-to-kidney circulation time is then determined by means of intravenous dehydrocholic

acid (Decholin) or radioactive tracer material. Five minutes after the loading dose, 50cc of 90% sodium diatrizoate is injected rapidly through a large bore needle, and films are exposed at the determined circulation time and at rapid intervals thereafter. The initial film is intended to outline the arterial system of the kidneys and, in practiced hands, often shows an excellent arterial phase. However, the timing is critical, and the diagnostic quality is not as good as that obtained by renal arteriography.

The nephrographic phase of the intravenous urogram is also useful in diagnosing renal vascular disease associated with hypertension. While it is possible to obtain sufficient parenchymal visualization by early sequence films at 15 seconds, one, and two minutes after injection of the standard 30cc dose of contrast substance, the increased nephrographic effect associated with high volume doses enables better differentiation of minor differences in renal opacification.

Proper tomographic examination of the kidneys often requires views at various levels in order to demonstrate multiple lesions or to define the limits of a large lesion. At times both the kidneys cannot be well demonstrated at a single level, because of normal variation or displacement of one kidney by an extrinsic mass. For this reason, one may prefer a method elaborated by Schencker,[16] which he termed "drip infusion pyelography." All of the advantages noted by Friedenberg and Carlin in their high volume technique are present with the drip infusion method; at the same time, a lasting nephrographic phase is produced which permits an unhurried examination of the renal parenchyma by conventional or tomographic methods. No arterial phase is demonstrable, but otherwise nephrograms of comparable quality to those obtained by the Evans method can be achieved.

The principle of the drip infusion technique is to achieve complete filling of the urinary tract in the hydrated patient through the diuretic effect of the rapid infusion of a mixture of Hypaque-50 and 5% dextrose in water. Schencker recommends using 1cc per pound of body weight of 50% sodium diatrizoate mixed with 1cc per pound of 5% dextrose in water. The minimal adult dose is 150cc of each. The mixture is given by means of intravenous infusion and is allowed to drip rapidly through an 18 gauge needle over a period of six to 10 minutes. Optimal parenchymal opacification occurs at the end of the infusion, and there is progressive filling of the entire collecting system thereafter, usually reaching a maximum 20-30 minutes after the start of the infusion.

Complete visualization of the collecting systems, the entire length of both ureters, and the bladder is almost routinely possible. Pyelograms of diagnostic quality may be obtained in patients who have elevated blood urea nitrogen levels and in whom the routine intravenous pyelogram would show little or no excretion of contrast substance (fig 2).

Early sequence films for the diagnosis of differential parenchymal opacification between normal and ischemic kidneys (fig 3) can be accomplished with the infusion technique, the recommended exposure times being two, three, four, and five minutes from the beginning of the infusion. A 20 or 30 minute film is then taken for demonstration of the complete urinary tract. Thereafter, the "washout phase" is recorded by films every five minutes for 20 minutes after the infusion of 600cc of normal saline containing 40gm of urea. The normal kidney will show a washout of contrast substance, where the ischemic kidney will show a retention and hyper-concentration of the contrast substance. The importance of performing the washout test has been emphasized by a number of authors,[1, 11, 18] who have reported a high correlation between the washout studies and split renal function tests, aortograms, and the findings at surgery. Schreiber and coworkers[17] maintain that a normal washout pyelogram excludes unilateral renal artery insufficiency, and an abnormal study is a definite indication for further confirmatory tests.

The chief disadvantage to the infusion method of pyelography is the cost. With a minimum adult dose of 150cc of sodium diatrizoate, the cost of the contrast substance alone is $8.50, and for a patient weighing more than 200 pounds, the cost of the contrast substance plus the intravenous infusion apparatus can amount to nearly $15. This price possibly could be decreased if the pharmaceutical houses would package the material in larger volume vials. If the cost per examination can be reduced, the infusion method offers obvious advantages over the standard method for use in routine pyelography. The complete filling of the urinary tract at a predictable time permits fewer exposures, decreasing the amount



Fig 2
Infusion urogram; 24-hour delay film showing large calculus obsrructing the right upper ureter. 83 year old male; BUN 65.



Fig 3
Left renal infarct; 59 year old male. Infusion urogram; tomogram taken eight minutes after start of infusion. Note differential parenchymal opacification left upper pole.

of radiation to the patient. The excellent demonstration of structural detail obtained almost routinely obviates the need for repeat examinations, and retrograde studies may be avoided in many cases.

Assuming that the economic barrier cannot be overcome, what are the indications for using this method? 1) The infusion pyelogram is indicated without a preliminary standard pyelogram when the BUN is elevated, in which case it may be assumed that the standard method will show little or no concentration and result in an unsatisfactory examination. 2) The prolonged nephrographic phase is advantageous for tomographic studies in the diagnosis of space-occupying lesions of the renal parenchyma; therefore, the infusion technique is indicated whenever a renal tumor is suspected clinically or on the basis of a plain film of the abdomen. 3) It is indicated when it is necessary to completely outline both ureters in their entire length in order to demonstrate displacement due to extrinsic pressure. 4) It should be used when the collecting systems are not well defined by the standard urogram and a retrograde examination would ordinarily be done only to demonstrate same. 5) It should be done in all hypertensive cases referred for renal evaluation. The techniques noted above provide the most satisfactory visualization of the nephrographic phase of excretion, and the washout test can be easily performed through the intravenous infusion already in place.

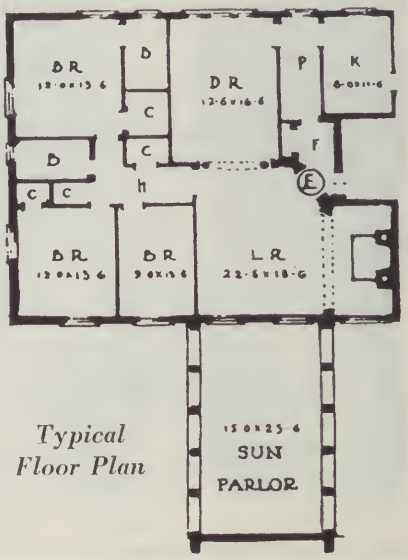
What are the contraindications for the infusion pyelogram? Obviously, a sensitivity to iodinated contrast substances, determined by history or by the intravenous test dose, prohibits their use in urography or any other iodine contrast study. A precarious cardiovascular status, while not an absolute contraindication, necessitates caution in giving a rapid intravenous infusion. On the other hand, the injection of contrast substance is better tolerated in the hydrated state by the patient with renal insufficiency. Finally, patients known to have plasma cell myeloma probably should not be given intravenous contrast substance because of the risk of precipitating anuria, as has been reported in several isolated cases. However, since the proteinaceous casts which have been found plugging the convoluted and collecting tubules at autopsy are thought by some authors to be the result of dehydration and increased urine concentration, causing precipitation of Bence-Jones protein rath-

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er than the iodinated contrast substance,[14] the infusion technique may prove to be the procedure of choice in this group of patients.

GENERIC AND TRADE NAMES OF DRUGS

Dehydrocholic acid—*Decholin*
Dextran—*Dextran, Gentran*
Sodium diatrizoate—*Hypaque*

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In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

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BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

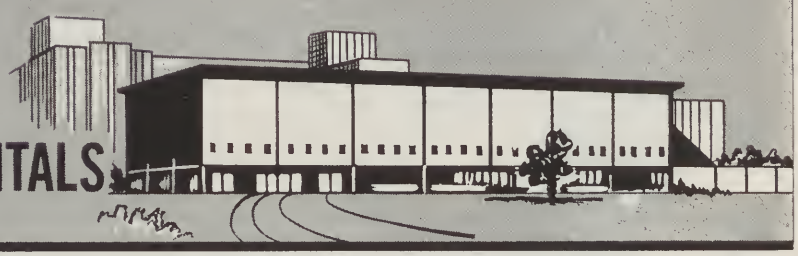
SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

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History of the Baltimore City Hospitals

BY DOUGLAS CARROLL, M.D.



Surprisingly little attention has been paid to the changing patterns of medical care in the United States. A study of the evolution of a public institution may be helpful in understanding the broad political and philosophical presuppositions of the times. In studying the transformation of the Baltimore Almshouse into the Baltimore City Hospitals, one might expect to discover in its attitudes and practices toward its patients a particularly sensitive key to the culture of the community. The way a municipality treats its most unfortunate citizens is a measure of its moral temperament.

This study has revealed several clear tendencies in the evolution of the Baltimore City Hospitals. First, large improvements in patient care have evolved only after major, sometimes revolutionary, changes in philosophical, moral, religious, social, or scientific attitudes and thought. These changes, however, have been gradual and not clearly recognized at the time. Second, all of these creative new ideas have been imported from Europe, most frequently from England, France, and Germany. Third, social progress has lagged far behind scientific advance and continues to do so today. Fourth, the Almshouse has shown an uninterrupted trend from a general institution for the solution of all community social problems to an institution for medical care. Fifth, financial responsibility for the Almshouse has fitfully passed from the City of Baltimore to be shared by the state and finally by the federal government.

Chapter 1.—The First Almshouse: Abating a Public Nuisance (1773-1822)

An Almshouse is, in its nature, merely an asylum for poverty. Here the poor, without respect to age or sex, have a right to find food and shelter. If it provides medicine and professional attendance, it is because these are inevitably incidental to such an establishment, and not because they are the objects of it.[1,2]

THE FOUNDING OF THE BALTIMORE COUNTY ALMSHOUSE

From the earliest times in America, the sick poor were cared for under a system inherited from England (the Elizabethan Poor Law of 1601). This English law traced its origin to the sixth century medieval Italian parishes, where tithes were collected locally by the parish church and were used to take care of the infirm and orphans.[3] Tithes were the first universal income tax. Local administration of welfare services, although never adequate, continued in the United States up to the great depression of the 1930's. It took the major social revolution of the 1930's to bring about recognition that the federal government had obligations for the welfare of its citizens.

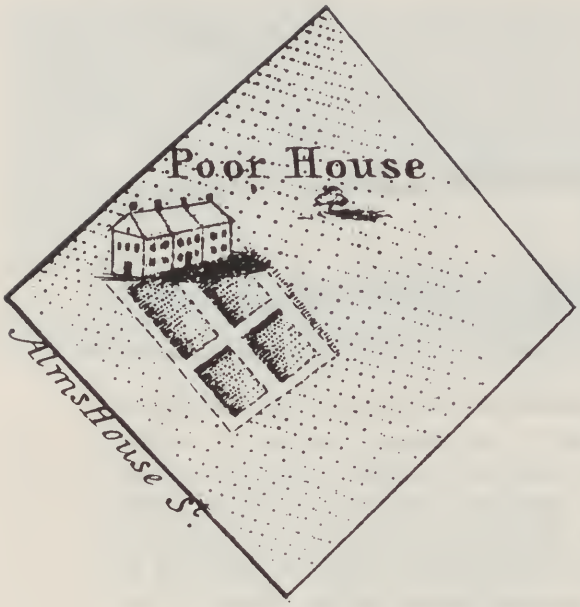


Fig 1

We have been unable to locate a good picture of the first Almshouse (1774-1822). The sketch was reproduced from Warner and Hanna's 1801 Map of Baltimore (revised from survey of 1797). This building was erected at Biddle and Eutaw Streets in 1774. The dome and east wing were destroyed by fire in 1776. The main building was rebuilt immediately, but the east wing not until later. This building served all the needs of the indigent of Baltimore. It was an acute, chronic, and lying-in hospital, a workhouse, and a shelter for vagrants, criminals awaiting trial, the insane, foundlings, and the old and infirm.

When the population in the colonies reached a certain level, it became cheaper to care for the poor by building an almshouse. Prior to the beginning of the almshouses, taxes were set aside by the various counties to pay individuals for taking care of the infirm and orphans. The Boston Almshouse was built in 1680. In New York, the ancestor of Bellevue Hospital was started in 1736. In Charleston, SC, the forerunner of Memorial Hospital was founded in 1738; in Philadelphia,[4] the beginnings of the Philadelphia General Hospital were laid in the Almshouse of 1742. The Baltimore County Almshouse was founded in 1773. These institutions were not founded as hospitals but as depositories for the poor.

Before the Revolution, Baltimore, the youngest of the large eastern seaports, was of little consequence. The activities of the war, the growing population, and the meeting of the Continental Congress in Baltimore in 1777 contributed to its growth. By the end of the Revolution, its population was estimated at 8,000.

In 1773, the Maryland legislature voted 4,000 pounds in bills of credit for the purchase of land and the erection of an almshouse and work house. The first Almshouse was located on a 20-acre plot, site of the present Richmond Market. Within a year of its building, a fire broke out in the garret destroying most of the building. It was immediately rebuilt.[5]

The institution was divided into two sections. Beggars, vagabonds, and vagrants were sent to the Workhouse and were required to work. The other section, the Almshouse, was for the poor and infirm. From the beginning, a doctor was associated with the Almshouse to care for the large number of sick, who were housed in an infirmary in the Almshouse.

GROWTH OF WELFARE SERVICES IN AMERICA

The dumping of all the social problems of the community into a single institution was designed more to save money and administrative headaches than to help the sufferer. In 1779, however, the legislature authorized the Trustees of the Poor to pay a pension of $30 maximum to 10 persons in circumstances particularly unsuitable for the Poorhouse.[5] Those who remained in foster homes must have been the favored few, for some citizens objected to the provision of any relief at all to the poor.

Welfare services in the United States have always rested on a largely accepted body of opinion that no one should be allowed to starve or suffer for shelter or clothing. This middle ground has, for centuries, been unsuccessfully attacked by advocates of limited government, laissez-faire, social Darwinism, and puritan moralists. For example, in 1786, the Rev. Joseph Townsend, an English clergyman, in his "Dissertation on the Poor Laws," objected to the provisions of the Poor Law. He said that only hunger could goad a man to work, and it would be unfortunate if the poor were helped because there would be no one left to do the most difficult, sordid, and ignoble jobs. He

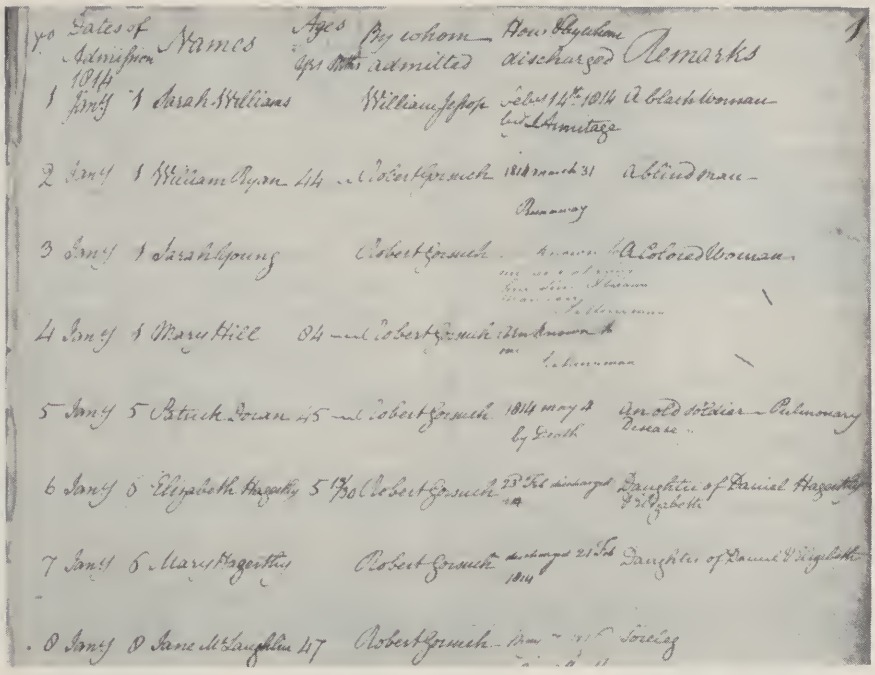


Fig 2

Almshouse admission and discharge book (1814-1826). This large book was started February 20, 1814, and all inmates of the Almshouse were listed. The patient's number, name, age, person who admitted patient, disposition with date, and miscellaneous remarks were entered in columns for each patient. Two hundred and sixty-four inmates were in the Almshouse on February 20, 1814. One patient had been admitted in 1778, but most were much later and stayed for only a few months.

There were 8,317 admissions between February 20, 1814, and May 25, 1826, when the book ends. Reasons given for admission are as follows: "By birth," "Blind," "Poverty," "Deranged," "Idiotism," "A drunken fellow," "A vagrant," "Consumption," "Pregnant." A small number of inmates were criminals admitted to serve up to seven years. Others were admitted as emergencies, as foundlings. No patient was admitted as a transfer from another organization; nor is there any record of an inmate's being discharged to a hospital or other institution.

thought that compulsory provision of relief under the Poor Laws kept wages from falling and, therefore, should be abolished.

From the opposite side, welfare services have been attacked as being too limited. Improved living conditions, education, training, unemployment insurance, and health services have been urged in the Judeo-Christian tradition by those who see the government as responsible for its citizens and particularly effectively by labor unions and the elderly.

A number of charitable organizations were founded in England in the late eighteenth century. In 1796, Sir Thomas Bernard founded the Society for Bettering the Condition and Increasing the Comforts of the Poor. Health insurance had its beginning in the Roman Catholic Sick Club of Norwich in 1782.

EIGHTEENTH CENTURY PHYSICIANS AND HOSPITALS IN AMERICA

There were three types of physicians in America at the time of the Revolutionary War. A few had been highly trained in Europe at the feet of the

great clinical masters. Others had learned as apprentices to physicians in practice. Their training often consisted of being their preceptor's pharmacist. In addition to learning about herbs and drugs, many read the standard European textbooks of the time: Sydenham, Van Swieten, and Boerhaave. Only a few had attended one of the medical schools in America. Medical schools offered lecture courses taken after an apprenticeship. The third group had little or no training but had the audacity to set out their shingle and call themselves physicians. Many were pure quacks, but it was even more difficult in those days to distinguish between a quack and a well trained physician than it is today. Diagnosis of internal illnesses was almost unknown. Only the obvious traumatic injuries were accurately recognized.

The oldest hospital in the colonies, the Pennsylvania Hospital, chartered in 1751, was financed by public subscription and a grant of 2,000 pounds from the Pennsylvania Assembly. Such hospitals catered to patients with acute illnesses, had a board of trustees drawn from the leaders of the community, and took mainly surgical cases.

Most physicians spent their time in home visits, for the well-to-do patient would not think of coming to the hospital except for surgery or injury. Deliveries were performed in the home, often by midwives, but by a physician if the patient was wealthy and lived in a large city.

The danger of infectious diseases in general hospitals was well known. A second type of hospital was the pest house, usually operated only during epidemics. Smallpox, yellow fever, malaria, typhoid, typhus, cholera, and dysentery constituted a large part of medical practice. When these diseases occurred in a hospital or other institution, many inmates died. Special hospitals to isolate these people from the community were, therefore, demanded during epidemics. When the threat was over the hospital closed.

A third type of hospital was that attached to every almshouse to care for the infirm and sick inmates. Out of these institutions developed some of the largest municipal hospitals of today: the Philadelphia General Hospital, Bellevue in New York, Memorial Hospital in Charleston, and the Baltimore City Hospitals.

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A central Poison Information Center is now in operation to serve the entire state of Maryland. THIS SERVICE IS PRIMARILY FOR PHYSICIANS and is available 24 hours a day, seven days a week. The Center will also give authorized first aid instruction to laymen who call until they can reach their physician or an emergency ward. Inquiries from physicians will be handled by paramedical personnel experienced in locating technical information. Medical consultation is also available. The existing eight poison control centers in Maryland will continue to function primarily as treatment centers.

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Revised Regulations Relating to Communicable Diseases

First Amendment

Paragraph -03 *RULES AND REGULATIONS* (page 43) is amended as follows:

0302 **Reportable Diseases**

Amebiasis	Hepatitis:	Psittacosis
Animal bites	" infectious	Rabies
Anthrax	" serum	Rocky Mountain spotted fever
Botulism	Industrial or occupational diseases	Rheumatic fever
Brucellosis	Leprosy	Rubella
Chancroid	Leptospirosis	Salmonellosis including typhoid and paratyphoid
Chickenpox in adults	Lymphogranuloma venereum	Shigellosis
Cholera	Malaria	Smallpox
Diarrhea of newborn	Measles	Staphylococcus infection, newborn
Diphtheria	Meningococcal infection meningitis	Streptococcal infection, including scarlet fever
Encephalitis	meningococcemia	Syphilis
" primary	Meningitis, other	Tetanus
" post infection	Mumps	Trichinosis
Food poisoning	Plague	Tuberculosis
Gonococcal infection:	Poisoning or adverse reactions from drugs or other toxic agents	Tularemia
" urethritis		Typhus fever
" vulvovaginitis	Poliomyelitis	Whooping cough
Ophthalmia neonatourm		Yellow fever
Granuloma inguinale		

030201—The above list of reportable diseases was adopted by the Board, December 30, 1965, and may be changed at any time by action of the State Board of Health and Mental Hygiene.

030202—All cases of the following are to be reported to the local health department immediately by telephone:

Animal bites	Cholera	Rabies—in animal and man
Anthrax	Food poisoning	Smallpox
Botulism	Leprosy	Typhus
Chickenpox in adults	Plague	

On receipt of notification of any of the above diseases or occurrences, special instructions for control will be issued by the local health officer.

030203—An outbreak of any disease or condition, of known or unknown etiology, which may be a danger to public health, occurring in three or more persons, or any unusual manifestation of a disease in an individual are to be reported to the local health officer who shall in turn notify promptly the Commissioner of the State Department of Health.

030204—The following diseases are to be reported weekly by total number of cases and not by individual case reports in accordance with instructions issued by and on forms provided by the State Health Department:

Measles	Streptococcal infections, including scarlet fever
Mumps	
Rubella	

030205—All other reportable diseases not mentioned in 030202 and 030204 are to be reported promptly to the local health department or the State Department of Health by individual case reports, in accordance with instructions issued by and on forms provided by the State Health Department.

Amended December 30, 1965, State Board of Health and Mental Hygiene.

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WASHINGTON COUNTY

A large proportion of the society attended the November dinner-business meeting, at which **Mr. Dixon Evander** discussed the new Faculty-sponsored accident and health policy and major medical insurance. A movie on medicare was shown.

The County Medical Society endorsed a resolution proposed by **H. H. Gist, MD,** favoring the formation of supervised junior high school football, as opposed to the current status of unsupervised football games played by junior high school children.

New officers of the society are **Richard A. Young, MD,** president; **Richard T. Binford, MD,** vice president; **John W. Clark, MD,** secretary; and **Sidney Novenstein, MD,** treasurer. The outgoing president, **Joseph C. Crisp, MD,** summarized the accomplishments of the County Medical Society during the past year.

* * * * *

A health fair was held at the North Hagerstown High School on November 13 and 14. This was jointly sponsored by the Washington County Medical Society and the Community Services Council of Washington County. The chairman of the fair was **Richard A. Young, MD.** Fourteen groups participated as exhibitors. Approximately 10,000 people visited the fair during the two days. This is the first fair of its kind ever held in Washington County and, as far as we know, the first health fair in the state. A repeat is planned for next year. The medical society demonstrated a plastic lady, supplied by the AMA, and the Woman's Auxiliary performed urine and blood tests for diabetes, using Ames diagnostic apparatus.

John W. Clark, MD, DDS

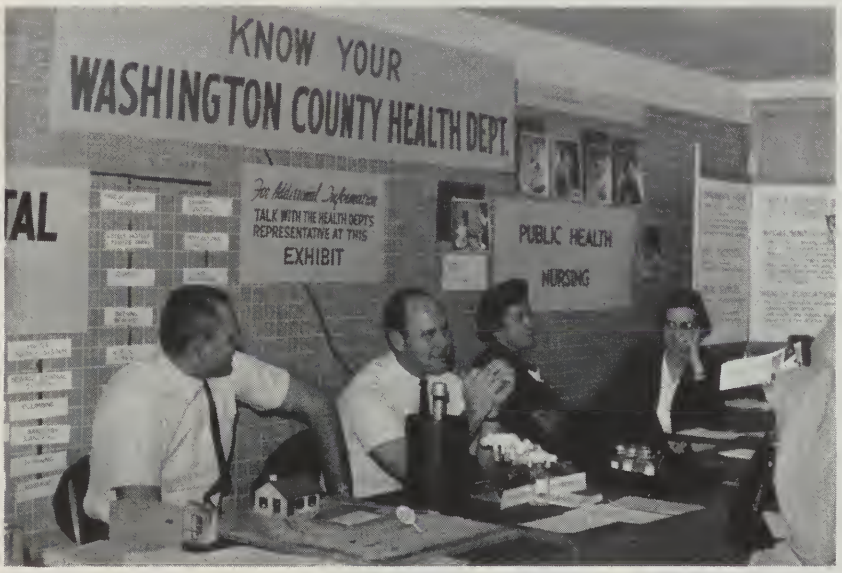


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Washington County's Health Fair



The Washington County Medical Society featured a plastic lady at its first health fair. *Left to right:* Archie R. Cohen, MD, Richard A. Young, MD, and Mrs. Jack H. Beachley.



Representing the Washington County Health Department, *left to right:* Nelson Tillou and John Waldrin, sanitarians; Mrs. Rosalie Paul and Mrs. Leona Hettenhouser, public health nurses.

WICOMICO COUNTY

In observance of Community Health Week, the Wicomico County Medical Society publicized immunization, using 60 radio spot announcements over two local stations, and several news stories in the local newspapers. An editorial in *The Daily Times* also stressed the importance of this health protection and commended the society for its campaign in the public interest.

* * * * *

Talmadge Reeves, MD, appeared as a panelist for District Four, Maryland Nurses Association, during its day-long mental health seminar in mid-November in Cambridge. Dr. Reeves discussed care of mental patients in general hospitals and their relationship to mental hospitals.

* * * * *

William P. Sadler, MD, contributed to an advanced first-aid training program for members of several fire departments and their auxiliaries by providing a program on closed chest cardiac massage on December 1.

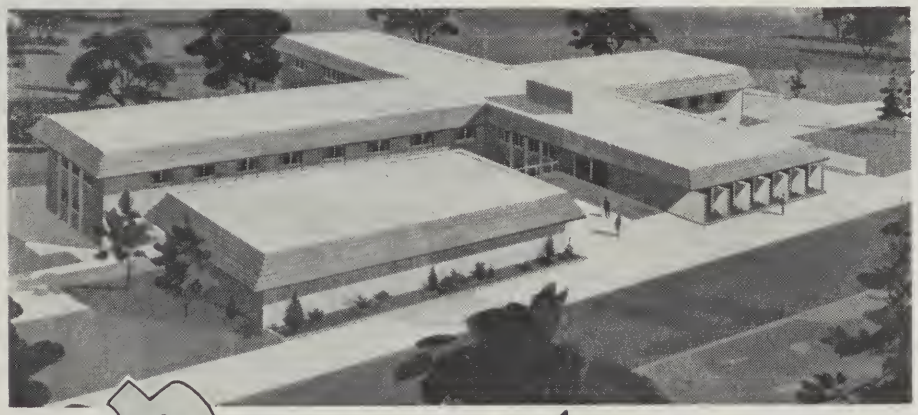
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William S. Womack, MD, and **Richard E. Hughes, MD,** answered questions on uterine cancer control after showing a special movie at a Salisbury theater on November 29. This was in cooperation with the Salisbury chapter of the Maryland Cancer Society. **James P. Gallaher, MD,** appeared on a television panel on November 26 as part of the same project.

* * * * *

John Sargeant, executive secretary of the Medical and Chirurgical Faculty, was guest speaker at the November meeting of the Wicomico County Medical Society. He discussed a number of activities of the Faculty and answered members' questions. The December program was provided by several members of Jehovah's Witnesses, who discussed ways in which their religious beliefs might affect medical care.

Mrs. Kit Hargreaves



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Ivory U. Sully, Jr., MD, was elected president of the Worcester County Medical Society at its October meeting. Dr. Sully practices general medicine in Berlin.

Born in Richmond, Va., he attended public schools there and graduated from Virginia Union University in 1936 with a Bachelor of Science Degree. He then went into the insurance business until his induction into the Army in 1943. He served in the army until December, 1945, attaining the rank of first sergeant. He was in the European Theatre of Operations.

In 1948 Dr. Sully completed residence requirements for the Master of Science Degree at the State University of Iowa. He studied medicine at Howard University Medical School and was granted his Doctor of Medicine degree in 1952. After completing his internship at DC General Hospital, Dr. Sully entered practice in Berlin.



Dr. Sully

Other officers of the Worcester County Medical Society are **Robert LaMar, MD,** vice president; **Francis J. Townsend, Jr., MD,** secretary-treasurer; **Frank Gantz, MD,** delegate to the Medical and Chirurgical Faculty; **Dr. Sully,** alternate delegate; **Norman R. Sartorius, Jr., MD,** Planning Committee representative; and **Paul Cohen, MD,** Journal representative.

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*Free, V., and Dawson, A.: Brit. J. 1:293, 1965.

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The Genetics of Essential Hypertension

PETER RASMUSSEN, MD
Associate Professor of Pathology
University of Maryland School of Medicine

As physicians, we sometimes distort medical reality to suit preconceived notions which arise through the influence of our prior incomplete experience. Such distortions, for example, gave rise to early humoral theories of disease. Such a distortion also has been the case in descriptions of the nature of essential hypertension.

In the early part of the 20th century, as retrospective pathologic descriptions gradually agreed upon the similar morphologic aspects of this disease from patient to patient, and as family observations indicated that persons within the same family tended to resemble one another in adjacent generations with respect to morbidity and mortality phenomena accompanying higher blood pressures, the assumption gradually became accepted that the entity was largely determined by heredity and due to a single dominant gene. High blood pressure without obvious cause *seemed* to be a homogeneous disease entity.

Some studies[1] pointing to discrepancies in the inheritance patterns were often explained away as showing up the variable penetrance* of the gene or inadequate anamnesis in the study. Hamilton et al[2] were among the first to indicate that these discrepancies and others might be due to an inadequate genetic hypothesis. They postulated that rather than a single dominant gene causing actuarily earlier death from high blood pressure, several genes might be present which collectively are partly responsible for this elevation in pressure, and that similarities in individuals of families in the same or contiguous generations might be due to the sharing of these genes by parents and siblings. They also suggested that variability in the environment probably contributed substantially to the blood pressure variability which a given population might demonstrate. Thus, the discrepancies in the "dominant gene" hereditary patterns of individuals in so-called hypertensive families might be due in part to environmental differences among its members or to the breaking up or dilution of the necessary gene combinations during meiosis, or perhaps to both of these phenomena.

These investigators have argued that no one has ever successfully shown a bona fide dichotomy of hypertensives versus non-hypertensives in any population of humans. In fact, they have asserted, such a dichotomy does not exist; average blood pressure levels vary among people just as heights vary. Thus the clinical distinction of hypertensive and non-hypertensive is an impressionistic view of reality, just as calling people tall, medium, and short is a convenient classification; but it is impossible to document objectively as having any incisive trichotomous biological meaning. The selection of any single value in inches or centimeters to distinguish tall individuals from medium individuals would be completely arbitrary.

In addition to the above cited discrepancies of observed to predicted Mendelian segregation with regard to manifestations of high blood pressure, considerations from an evolutionary and population genetics point of view detract from the credibility of a single dominant gene's being the chief cause of blood pressure variability in a given random population. Considering the high

*Penetrance refers to the frequency with which a gene manifests itself in the population. A gene with low penetrance is present in chromosomes but often will not show any of its effects.

percentage of morbidity and mortality from high blood pressure (one review citing 5-25%[3]), the frequency of this single gene would have to be unusually high to account for these phenomena. Well-documented single dominant genes causing diseases which permit marriage and parenthood are not found to exhibit such high gene frequencies in affected populations. In order for a single detrimental gene to have reached even moderate frequency in a population, it usually must have been favorable at some time in the past and then become detrimental because of a change in environment; or it must be appropriately favorable in many persons of the population even though unfavorable in most; or it must have an unfavorable effect when in contact with some other genes in the population, the latter genes having come to the population from another population. None of these situations appears to have been the case in populations having significant morbidity or mortality because of higher blood pressure, although the higher hypertensive morbidity and mortality in the American Negro may be an exception.

Thus, reconsideration of the consequences of the inconsistencies in the single gene hypothesis directs one's attention to the only other alternative, in what appears to be a disease with at least partial genetic determination: a polygenic hypothesis. How can we physicians, as retrospective observers of disease (and pathologists as the most retrospective observers of them all), reconcile such a seemingly diffuse explanation with what we know to be the nature of this retrospectively distinctive clinicopathological entity, essential hypertension? The answer is, I believe, that polygenic inheritance need not imply diffuseness.

During the evolution of the total vascular system of *homo sapiens,* great numbers of selective environmental forces must have acted on the system in a detrimental fashion, the continuing result being successful survival and continuance of those favorable gene combinations which on the average reproduced themselves in greatest numbers. Therefore, as our contemporary human environment has changed and permitted greater longevity, formerly evolved complex genetic variability currently contributing to some unfavorable variability in the derived unit blood pressure would be a rather plausible course of events.

In contrast to the situation in the case of single genes, the survival of blocks of many genes relatively stable from generation to generation and favorable to the evolution of a biologic system, such as the vascular tree, appears to be the rule in the evolution of a genetically well integrated species such as man. Thus transmission of these blocks of genes occurs in much the same manner that single gene transmission does, although some blocks may break up or rearrange themselves during meiosis.

These disruptions of blocks give rise, in part, to the phenomenon which has come to be called penetrance. In the case of blood pressure morbidity, the rearrangement or breakup of polygenic blocks during meiosis might partly explain sporadic cases of hypertension or the familial aggregations of this entity which lack crisp Mendelian segregation. To say that any such system formerly evolving in favor of a population may later be responsible for death of individuals is only to restate what we know of life in complex organisms: that all such organisms die ultimately because of incompatibilities with their environments.

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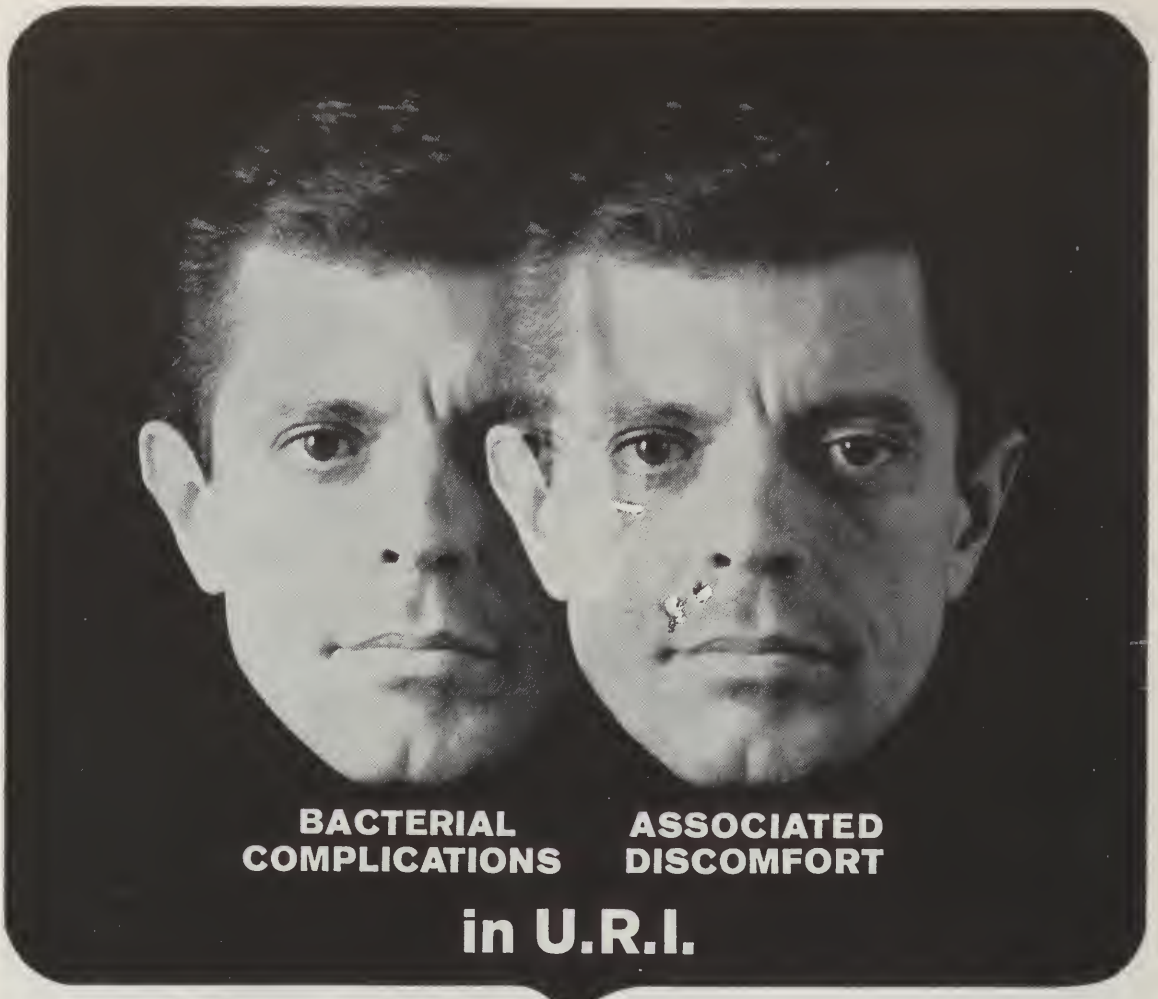
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The Heart Page

Joseph C. Fitzgerald, MD—*Editor*

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Post-Resuscitation Care After Cardiac Arrest

DONALD H. DEMBO, MD
Chairman, Closed Chest Cardiac Resuscitation Committee
Heart Association of Maryland

Total management of sudden death with expired air ventilation and closed chest compression must include intensive post-resuscitation care. A common experience has been successful restoration of spontaneous cardiac activity and respiration, followed by death within a few days from renal failure, central nervous system damage, electrolyte imbalance, or underlying disease.

Closed chest compression, even when adequately administered, produces only two-thirds of normal cardiac output. This reduced circulation when compounded by inadequate oxygenation results in brain, renal, and other tissue damage. During resuscitation one must maintain an adequate airway, provide continuous ventilation with high oxygen concentrations, and avoid pressure-cycled ventilation devices which function inadequately during chest compression. There must be frequent and repeated use of cardiotonic drugs (epinephrine at five minute intervals) to increase perfusion pressure. However effectively applied, metabolic acidosis occurs and should be combated with sodium bicarbonate given at 10-minute intervals.

In the immediate post-resuscitation period, hyperventilation is often observed as a respiratory compensating mechanism. Support of ventilation at this time with pressure or volume cycled equipment may be necessary. However, hyperventilation may induce respiratory alkalosis with a concomitant fall in serum potassium. This can produce serious arrhythmias, particularly in digitalized victims. Adequate equipment for resuscitation must, therefore, be able to monitor electrolytes and analyze blood gases and pH to permit corrective therapy when indicated.

The brain, highly sensitive to oxygen deprivation, must be protected in the post-resuscitation period. In the presence of confusion, stupor, or frank coma, further brain damage should be prevented through the use of hypothermia. Cerebral edema may be reduced by the intravenous administration of urea. Urine production should be monitored with an indwelling catheter. Should urine output fall below 30cc/hour, an osmotic diuretic such as intravenous mannitol should be administered promptly and output maintained by additional mannitol as required.

Continuous monitoring of cardiac rhythm will promptly detect arrhythmias and permit specific treatment. Cardiac arrest may reoccur. The use of maintenance anti-arrhythmic agents, such as quinidine or procaine amide, may be helpful. Vasopressors in concentrated solutions are useful in maintaining adequate blood pressure, but their vasoconstrictive effect in reducing renal, cerebral, and coronary blood flow dictates that they only be used when actually needed. They may be of particular value in cardiac arrest after myocardial infarction when severe hypotension persists. In long standing hypotension and shock, capillary damage may result in significant pooling of body fluids with loss in effective circulating blood volume and electrolytes. Central venous pressure monitoring with an indwelling venous catheter will permit therapy as required.

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dotes for drug reactions, when available, and other specific measures should be instituted. The value of large doses of steroids has not yet been determined.

There appears to be correlation between survival and the swiftness with which spontaneous cardiopulmonary activity is restored. Prompt application of adequate closed chest compression and ventilation in cardiac arrest reduces tissue damage and, therefore, lessens post-resuscitation problems. Careful attention to detail in applying emergency measures, definitive treatment, and post-resuscitation care will increase survival after cardiac arrest.



REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Recent Advances in the Rehabilitation of Rheumatoid Arthritis

Personal and Social Aspects of Rheumatoid Arthritis

*DOUGLAS CARROLL, MD and ROBERT BRULL**

It is part of the cure to wish to be cured.— Seneca c. 60 AD.

In previous Rehabilitation Notes, certain aspects of the physical examination in rheumatoid arthritis, the use of physical therapy, newer diagnostic advances, and the use of orthopedic and hand surgical procedures have been presented. The crucial importance of follow-up in preventing loss of range of motion has been emphasized.

It seems appropriate to end this series with a discussion of the effect of rheumatoid arthritis on total life adjustment. An excellent study of this subject is that of Ostro[1,2] who investigated 125 ambulatory patients attending two New York City arthritis clinics. He studied their vocational, economic, family, and social problems. Seventy-eight patients had rheumatoid arthritis, 30 had osteoarthritis, and 17 had miscellaneous rheumatic diseases. At the time of interview, 45 of the 81 employed prior to the onset of rheumatoid arthritis were not working. Only 15 patients were never unemployed during their illness.

The physicians were asked for a clinical estimate of the patient's ability to work, based not only on the degree of arthritic involvement but also on the total medical status of the patient. Thirty-five of the 45 who were considered able to work were actually employed. *An interesting finding was that the severity and duration of the disease did not seem to have a close correlation with employment status.* In addition to the arthritis, factors limiting employment were old age, other diseases, distance of travel, negative feelings about returning to work, and inability to perform skilled or long term jobs.

Social investigation and direction helped many of the patients to become self-supporting.

Of the 81 patients who were self-supporting when symptoms began, 64 suffered financially as a result of the arthritis. Only 19 patients remained self-supporting throughout their illness.

Sixty-five of the women performed all housework before the illness, but after the onset, only 27 (mostly with osteoarthritis) could continue a full load of housework.

Marriages suffered increased strain because of reduced income and the patient's loss of status in the family.

During the summer of 1965, a study was performed at the Baltimore City Hospitals to learn what factors had been most important in causing dependency in welfare patients with rheumatoid arthritis. Sixteen patients were interviewed at length. Their homes were visited when possible, and their medical records were reviewed. As might be expected, severity of the disease was not

*Mr. Brull is a second year medical student at the University of Maryland School of Medicine.

the only factor which precipitated dependency. A few of the patients would have been on welfare even if they had never had rheumatoid arthritis. Others made heroic efforts to remain independent. Other factors which influenced dependency were family stresses and educational and vocational limitations.

Family.—In about half the cases, the relationship between the patient and the family deteriorated when the patient became sick. Deterioration generally was caused not by the disease but by underlying interpersonal relationships. The disease frequently exacerbated underlying hostility.

Among the other half of the patients were examples of unshakable loyalty despite disease. One son gave up a college education to support his mother at home; a brother completely supported a patient in his own home for years.

Education and vocation.—No patient had completed high school. One-half had less than a sixth grade education. Only one patient had a job above laboring or domestic work.

As in so many patients with chronic diseases, the disease itself was not the major cause of disability but often was merely the straw which broke the camel's back. This group of patients had little education, limited intellectual endowment, and narrow vocational potential. There were wide variations in motivation, passivity, and dependency needs.

A recent sophisticated study[3] of 49 women with rheumatoid arthritis used the Minnesota Multiphasic Personality Inventory (MMPI). The patients were divided into two groups. In the first group, the stage of progression of the illness was less than the class of functional incapacity (using the American Rheumatism Association criteria). The second group consisted of patients whose stage of progression was greater than or equal to the class of functional incapacity. In other words, the first group seemed to be incapacitated by less progressive stages of rheumatoid arthritis than the second group. The two groups were then compared according to the MMPI. Certain differences were statistically significant.

In general, the first group (with severe functional limitations but relatively little progression of the disease) suffered a great deal of acute distress with a wide variety of psychological symptoms. These patients appeared to be unable psychologically to cope with the illness. They showed shyness, introversion, and alienation from self and others with decreased social participation and responsibility. Their increased anxiety, depression, and fear resulted in withdrawal from social contacts. They were more hostile and less able to control their impulses.

The second group (in which the degree of functional limitation was more appropriate to the advanced disease) showed less tendency to complain about physical symptoms, was less depressed, apathetic, and lacking in positive psychological resources.

The investigators concluded that the patient who best maintains function is able to cope psychologically with the disease. He does not manifest severe anxiety, depression, or dependency and tends to be an outgoing person despite his illness. Functional incapacity is associated with a breakdown of ego defensiveness and growing inability to cope with the symptoms.

The authors point out that patients with rheumatoid arthritis are far from homogeneous in psychological make-up. These generalizations may apply to any chronic disease and are not necessarily specific for rheumatoid arthritis.

SUMMARY

It is curious that the severity and duration of rheumatoid arthritis is not directly related to employability in ambulatory arthritis patients. A number of studies have shown that psychological and social factors are of major importance in determining how a patient with rheumatoid arthritis will perform in his environment. It is now clearly established that these factors are of almost equal importance with the disease process in predicting the performance of patients with rheumatoid arthritis. It is therefore incumbent on the physician to be sensitive not only to the patient's symptoms but also to the social and psychological setting in which they occur. Sometimes the latter factors may be modified more aptly than the progress of the disease.

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Chronic Bronchitis

JOHN P. LIGHT, MD

Chronic bronchitis is a long-standing disease of the tracheobronchial tree characterized by hypersection of mucus by the goblet cells of the submucosa of the respiratory tract. The stimulus for this excessive secretion of mucus is thought to be repeated insults to the tracheobronchial tree by bacterial, viral, or physical agents, such as polluted air or cigarette smoke.

Clinically, chronic bronchitis is characterized by a long history of cough and sputum production associated with recurrent respiratory illnesses and progressive dyspnea. The disease increases in frequency with age and occurs more often in men than in women. Pathologically, the mucous glands become hypertrophic, their ducts dilate, and the orifices of these ducts widen. Histologic examination of the bronchial submucosa reveals fibrous hyperplasia and thickening of their walls. Peribronchial inflammatory changes may be observed and occasionally peribronchial abscesses form.

Chronic bronchitis is often the precursor of destructive emphysema, affecting the area of attachment of the respiratory tissue (alveolar ducts and alveoli) to the bronchial tree (terminal bronchioles and respiratory bronchioles). The damaged bronchiolar walls retract, thus forming spherical spaces which, in turn, give rise to the centrilobular type of destructive emphysema. The prognosis for this disease is grave; death usually is attributable to pulmonary infection or cardiorespiratory failure.

From the Department of Radiology, University of Maryland School of Medicine.

In several large studies based on plain x-ray films of the chest of patients with proven chronic bronchitis, almost half show no radiographic abnormality. Sometimes there is evidence of pulmonary damage secondary to chronic bronchitis, ie, emphysema. The radiologic changes seen in pulmonary emphysema are related to hyperaeration of the lungs: little change in the appearance of the inspiratory and expiratory films, flattening of the diaphragm, small cardiac silhouette, widened intercostal spaces, prominence of the central pulmonary arteries, and attenuation of the distal pulmonary vessels. Tuberculosis, carcinoma, and bronchiectasis clinically may mimic chronic bronchitis, and the chest film helps to eliminate these possibilities.

Direct signs of chronic bronchitis may be seen occasionally on the plain chest film. There may be generalized tubular shadows seen coursing parallel to arteries, reflecting the abnormally thick bronchial walls. When seen in *en face,* these may have a ring appearance and are usually observed in the upper third of the lungs. These small densities may be interpreted as "granulomatous scars" if not examined carefully. The areas of parenchymal scarring described by the pathologist in chronic bronchitis are probably too small to be demonstrated radiographically. More rarely, a fine reticular pattern may be observed, especially in the lower lobes. This is caused by fibrotic areas about the alveolar walls or crowding together of the vessels by adjacent emphysematous areas.

The pathology of chronic bronchitis can be demonstrated by bronchography. The most characteristic change is opacification of the dilated



Fig 1

Bronchographic opacification of dilated mucous gland ducts in chronic bronchitis.

mucous gland ducts, seen as numerous small spikelike projections from the normally smooth bronchial wall (fig 1). The changes are best demonstrated in the main stem and lobar bronchi. Bronchiolar ectasis may be demonstrated bronchographically by a grapelike peripheral pooling of contrast material. These small spherical pools vary in size from several millimeters to a centimeter.

Occasionally the margins of the peripheral pool of contrast may not be smooth but may show a finely frayed edge having the appearance of mimosa blossoms (fig 2).

Another bronchographic characteristic of chronic bronchitis is the abrupt and sharp termination of a peripheral bronchus (the "broken bough" appearance) (fig 3). These clear-cut endings may be caused by intraluminal mucus or secondary to air trapping from an obstruction more distal in the bronchiole.

Bronchi which possess a beaded appearance



Fig 2

Mimosa blossom pattern in chronic bronchitis due to bronchiolar ectasia.

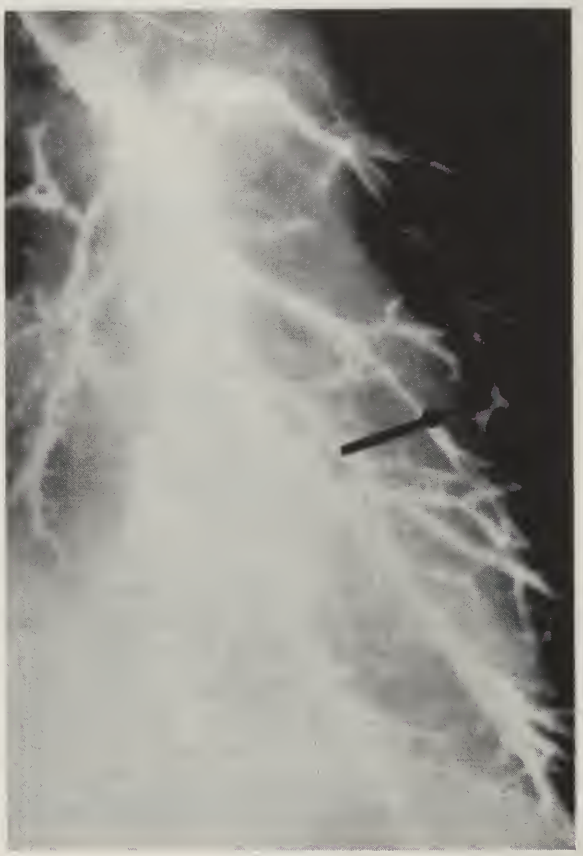


Fig 3

Abrupt termination of peripheral bronchi (the "broken bough" appearance) in chronic bronchitis.

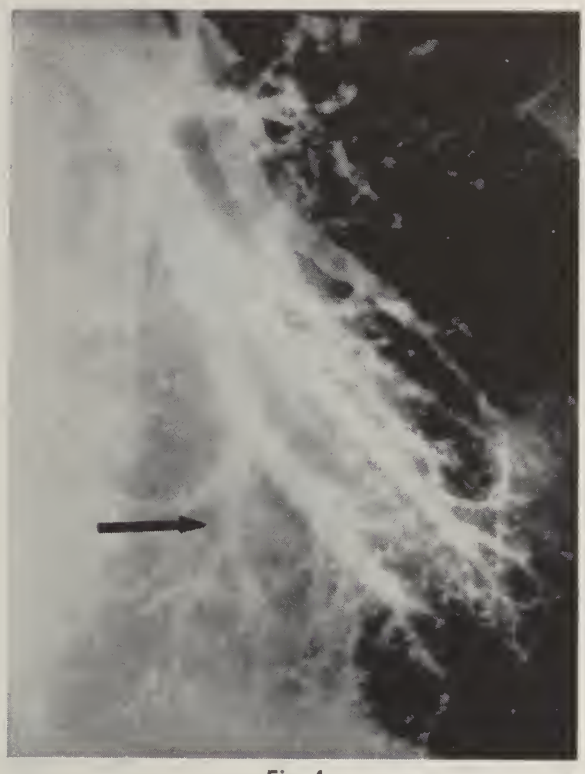


Fig 4

Beaded appearance of bronchi in a chronic bronchitic due to alternate areas of dilatation and narrowing.

may be seen. This reflects alternate areas of dilatation and narrowing due to bronchial wall thickening and retraction (fig 4). These peripheral bronchographic findings may be generalized or focal and should not be confused with alveolar filling which may occur with the use of bronchographic agents of low viscosity.

Cinebronchographic studies have made possible the observation that most bronchitic subjects show a disproportinate tendency to collapse their third stage bronchi with cough, expiration, and the Valsalva maneuver. This tendency is present to a lesser extent in the main stem bronchi and even the trachea.

In summary, chronic bronchitis is a serious disease of the tracheobronchial tree secondary to repeated biological or physical insults leading to excessive secretion of mucus and often to the centrilobular type of destructive emphysema and ultimate cardiorespiratory failure. Chronic bronchitis is rarely diagnosed by means of the plain chest film; however, pathognomonic changes can be demonstrated readily by bronchography.

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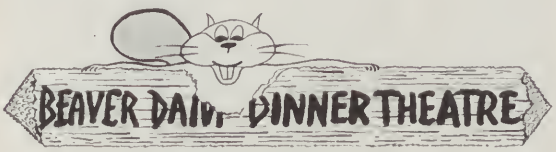
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Alcoholism
SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

TOWARD A COMMUNITY ALCOHOLISM PROGRAM

DAVID TRACHTENBERG, MD
Director
Montgomery County Health Department
Alcohol and Drug Dependency Program

ONE MAJOR DIFFICULTY in creating a comprehensive public health program for alcoholics is that they are indeed many and varied. No *simple* service is adequate to meet their needs.

To illustrate the multiple facets of service needed by every community, we might describe a typical family in which there is an alcoholic. Our subject, V.O., is a 37-year-old man, separated from his wife and four children. His drinking began 20 years ago, but both he and his family agree that he has been a *problem* drinker perhaps for only 10 of those years. He is a high school graduate, and for most of his working life has been a skilled electrician. Before his problem drinking began he was considered an excellent worker: honest, exceptionally diligent, and responsible; if anything, he worried a bit too much about doing a good job. Through his industry and ability, he provided well for his family. A "nice guy," he was well liked by all who knew him.

In taking this history, we discovered what may be a coincidence, that he began to drink more and more heavily shortly after he expanded his business. We also noted that during this same period his father died suddenly.

We encountered V. O. after he had been separated from his wife for about two years. The wife has the children and works. The children's school performance has been slowly deteriorating. The 16-year old boy had recently been in a little trouble with some friends, involving racing a car and drinking some beer.

V. O. has lived in a rooming house, or in several rooming houses. In the two or three months a year in which he went on the wagon, he managed to pick up some work of one sort or another, some of it in simple electrical jobs (he had fallen behind technically). In the past six months, however, he has been drinking constantly, scrounging money wherever he could to buy cheaper and cheaper wine, eating irregularly or not at all, losing weight, and recently developing weakness and numbness of the hands and feet.

We might have met our subject in the emergency room of a hospital, brought there by the police, who had picked him up as drunk and disorderly. The police would have brought him to the emergency room on that day because they noticed that in jail he was becoming more and more unsteady, had developed severe tremor of

Excerpted from a paper delivered to an open meeting of the Eastern Shore Council on Alcoholism, November 10, 1965, on "Guidelines for Local Alcoholism Programs."



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both hands and head, and seemed confused and frightened. Correctly they diagnosed him as being in early DT's.

This case, obviously typical, illustrates the varied needs of any treatment program. What are we to do with this man?

PRELIMINARY TREATMENT

Medical evaluation reveals that he is indeed in early delirium tremens (fatal in 25% of the cases if left untreated). He may soon go into convulsions or become acutely and dangerously agitated. He is seriously malnourished, with signs of early beriberi, and perhaps close to liver decompensation. Obviously he needs an inpatient medical facility which is also equipped to handle his agitated mental state. He could be expected to stay in such a facility for up to three weeks. On discharge he would be walking steadily, clear headed, and reasonably well nourished.

Discharged from the hospital with nowhere to go, with only alcoholic friends, with no emotional shoring up, he would almost certainly return to drinking. What he needs now is a more prolonged stay in a rehabilitation facility for social, psychological, and vocational evaluation, education concerning his disease, and introduction to the various therapies, including Alcoholics Anonymous. This segment of his treatment can best be conducted in a specialized alcoholic rehabilitation unit, such as those operating in our state hospitals.

Let us suppose that he remains in such a facility for six weeks. Together with his period of medical hospitalization, he has been in the hospital for more than two months. Where is he now? Physically he is feeling well; emotionally, he has had time to settle down and feels more confident and at ease in the hospital setting. He has learned a little about alcoholism and perhaps

begins to see how the various forms of treatment can help him in the future. For our part, we have learned a lot more about what's the matter with him and about how he came to drink. We have evaluated his family and home situation. We have investigated his vocational potential and we perhaps can begin to write a treatment prescription at this time. Notice that we have treated him medically, have given him a bit of education and some rest, and that is all. At this point we have essentially taken care of his immediate past but have done nothing for his future.

Our subject perhaps wants to go back to his home town but has no money, no job, no training; and his wife is understandably reluctant about allowing him back in the home. He still carries with him the internal conflicts and problems which initially led to his abnormal drinking.

The next stage in treatment might best occur in a half-way house in or near his community, where he would continue to receive support from other alcoholics who are doing well and from the half-way house manager and staff, themselves arrested and productive alcoholics. He might stay there for a number of weeks, perhaps a few months, while vocational rehabilitation was helping him to acquire the education and experience necessary to re-establish him as a capable electrician and to find a job. This accomplished, he might look around for suitable quarters outside the half-way house. By this time he has made new friends and no longer confines his relationships to other drinking alcoholics. He has been strengthened in his ability to deal with other people by his continuing association in AA and his attendance at an outpatient clinic, where he has participated in group therapy sessions. His occasional compelling impulses to drink are thwarted because he is taking his Antabuse regularly.

THE FAMILY PROBLEMS

V. O.'s family is beginning to notice that he is working and sober. His wife is still frightened about going back into that fearful drinking rut, but her own anxiety has been relieved by her attending Al-Anon sessions, where she herself has learned more about alcoholism and what she can do to help her husband.

It may be that one day the couple resolve to try it again, but this time they can do so with the assistance of family group therapy, where both husband and wife, along with other husbands and wives, discuss and work out their problems: the tensions, resentments, hurt feelings, and destructive patterns of interaction which have developed over the years and, unassisted, might continue to operate. Helping their chances for success in living together are visits from the public health nurse who, as an independent observer in the home, often can recognize early signs of serious degeneration in the family system.

While we are congratulating ourselves on how well V. O. and his wife are doing, we notice, however, that his 16-year-old son seems to be drinking more. He has again gotten into trouble with a bunch of boys, and his school grades are not improving.

We can, of course, chalk this off to youthful enthusiasm, childhood pranks, or laziness, except that we know that children of alcoholics, who drink, are more likely to become alcoholics themselves. We would be even more alarmed if both parents drank, because then we would know the odds would be one out of four. Perhaps a parent, school counselor, or juvenile court worker might alert those in the alcoholic program of what may be early signs of problem drinking or of maladjustment or problems in general. The boy could perhaps be evaluated and encouraged to participate in Alateen or, if necessary, become a clinic patient in a group with other early problem drinkers.

Using this clinical example, we have described the basic facilities of a community treatment program for alcoholics: 1) a medical inpatient unit to include detoxification facilities; 2) an inpatient alcoholic rehabilitation unit for extensive evaluation, education, and initiation of treatment; 3) outpatient clinic facilities offering primarily group psychotherapy for alcoholics and their families; 4) a half-way house to function as the bridge between inpatient facility and community; 5) educational programs to alert the population in general to the dangers and early signs and symptoms of alcoholism and to facilitate the identification of alcoholics in the various stages of their illness.



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Pediatrics

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WILLIAM STIFLER, JR., M.D., Chairman

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Preventable Neonatal Infections

Only by an awareness and constant surveillance of sources of infection and the use of techniques mentioned can one hope to combat the rise in the frequency of infections brought about in part by the increased use of hospital facilities, shortages of personnel and the increased use of mechanical equipment, parenteral fluid therapy and broad spectrum antibiotics.

S. WAYNE KLEIN, MD

Despite attempts to lower neonatal mortality, infections continue to be a primary cause of neonatal deaths. Particularly disturbing is the increasing frequency of reports of nursery infections due to the so called "soil and water" bacteria (*Flavobacterium, Achromobacter, Paracolon, Herella, Pseudomonas*). Reports of these organisms from the laboratory send the clinician back to his bacteriology book, where he is informed that these organisms are saprophytes and usually nonpathogenic for man.

Today, these soil and water organisms are responsible for severe and often fatal infections in both premature and full-term infants. All grow well wherever there is sufficient warmth and moisture. Humidifying chambers in incubators, oxygen administration equipment, sinks, sink traps, faucet aerators, and resuscitation and inhalation equipment are ideal for the growth of these organisms and, indeed, all have been reported as sources of infections for outbreaks of neonatal infections.

Recent studies of septicemia in the premature infant[1] have shown that a fourfold reduction in such waterborne infections can be achieved by the application of the following procedures.

1. Perform routine bacteriological survey.

All items that come in contact with water should be cultured routinely, not only in the nursery but also in the delivery rooms. This both locates possible sources of infection and monitors the effectiveness of the procedures used to eliminate these "water bugs" from the environment. Any item that is wet should be cultured.

2. Replace all tubing in traps on suction devices after each use.

Suction machines and resuscitators can be eliminated as a source of these organisms by establishing a routine which requires the replacement with sterile material of all tubing from the suction catheter down to the suction motor or wall outlet including the suction trap.

3. Replace oxygen humidifying bottles.

Oxygen humidifying bottles should be changed daily with sterile bottles, tubing, and water and never used for more than one patient.

4. Don't refill soap dispensers.

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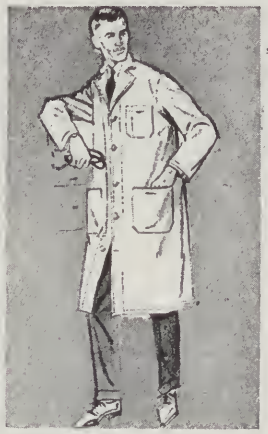
Dr. Klein is assistant professor of pediatrics, The Johns Hopkins University School of Medicine, and assistant chief of pediatrics, Baltimore City Hospitals.

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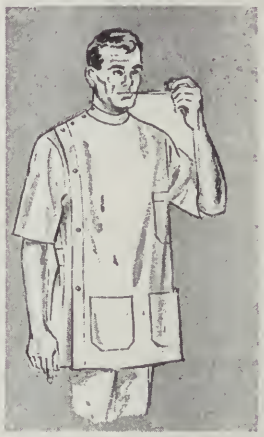




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should never be refilled but should be replaced with a sterile bottle containing fresh solution.

5. Use diluted acetic acid instead of sterile water in humidity reservoirs.

The use of 0.001 molar acetic acid inhibits the growth of gram negative organisms, especially pseudomonas, but is harmless to both infant and humidifying reservoir. (To prepare 0.001 molar acetic acid: add 4.0ml of a 2% solution of acetic acid to 1000ml of sterile water. This solution has a pH of 3.8 to 4.0).

Implementation of these procedures along with those previously recommended by the American Academy of Pediatrics[2] should eliminate many sources of gram negative infections. These techniques apply also to other hospital areas, such as intensive care units, where highly susceptible patients are located.

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REFERENCES

1. Buetow, K. C., et al: Septicemia in Premature Infants, *Amer J Dis Child* 110:29, 1965.
2. *Standards and Recommendations for Hospital Care of Newborn Infants,* American Academy of Pediatrics, 1964, page 63.



Maternal Welfare.

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Cases 8 and 9—Anesthesia Accidents

The first patient was a 25-year-old primigravida whose prenatal course was uneventful. She was admitted to the hospital in active labor at 2:45 AM on February 12, with the cervix 2-3cm dilated. General physical examination revealed no abnormalities. At 3:40 AM, the cervix was 5-6cm dilated, blood pressure 150/100. She was given 100mgm of Demerol and 3 grains of Seconal.

At 4:20 AM caudal anesthesia was begun by a resident physician and was completed at 4:30 AM. A total dosage of 20cc of metycaine was administered. Upon completion of the anesthesia administration, the cervix was fully dilated with the presenting part at the spines. Ten minutes after completion of the anesthesia, the patient appeared quite uncomfortable and vomited 200cc of greenish fluid. At 4:45 PM the blood pressure was recorded at 140/100 and the pulse strong and regular.

Five minutes later she became restless, began having labored respirations, and the pulse became irregular and feeble. She was given intravenous adrenalin, 1cc, and positive pressure oxygen was begun. Another five minutes later the patient's condition was critical, with the pulse not perceptible and heart sounds questionable. Her pupils were dilated and the corneal reflexes were absent. At 5 AM no pulse or heartbeat could be definitely noted, and at 5:10 AM respirations ceased and she was pronounced dead.

Since the fetal heart was still determined at 60 per minute, a cesarean section was performed with the patient in her bed, and at 5:20 AM a 6lb 6oz boy was delivered, who could not be successfully resuscitated.

Autopsy yielded no positive findings other than mild pulmonary edema and congestion of the lungs. A subsequent laboratory report demonstrated metycaine in the spinal fluid.

The second patient was 28 years old, para 5, gravida 6. She had received prenatal care from her family physician for six months before her admission to the hospital, at 10:30 PM on June 10. The prenatal course had been uneventful. On admission to the hospital she was in active labor, and the general physical findings were normal. She was given the usual preparation for delivery and taken to the delivery room at 11:50 PM, fully dilated.

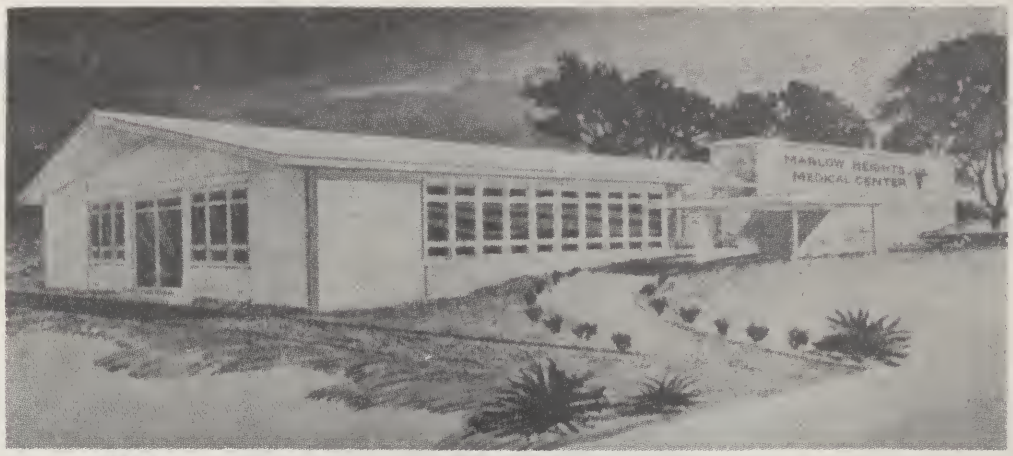
Ethylene and oxygen were administered, and soon thereafter the patient began vomiting. The chief anesthetist was summoned. It was thought that the patient had aspirated a large amount of semi-digested food. She was pronounced dead at 12:40 AM, June 11.

We do not know what attempts were made to clear the air passages or what other treatment was given between the time the patient began vomiting and the time of death. Autopsy was not performed.

COMMENTS

These two cases illustrate the all too frequent consequences of accidents of anesthesia. The need for skilled, trained persons to administer obstetric anesthesia is often overlooked. The committee voted both of these to be preventable maternal deaths on the basis of improper administration of anesthesia.

In the first instance, although such a mistake could happen in the best of hands, the experience of the resident physician in administering caudal



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anesthesia, presumably without supervision, is open to question. In the second instance, it should be an inflexible routine of any maternity service to ask patients in labor when they had last eaten solid food. Recognizing that the emptying time of the stomach is delayed in patients in early labor, inhalation anesthesia should not be administered when food has recently been eaten without first carrying out gastric lavage.



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IMMUNIZATION RECORD FORMS AVAILABLE IN QUANTITY

A supply of wallet-size immunization record forms for patients is available to Maryland physicians through the State Health Department. Space is provided for the first successful smallpox vaccination date, revaccination, and the physician's signature. Also included are spaces for each inoculation against diphtheria, whooping cough, measles, tetanus, and poliomyelitis, and blanks for any other immunization doses.

Under the patient identification lines is a section for information regarding any special sensitivity, allergy, disease, or condition which should be known to a physician giving emergency treatment. A note stresses the importance of follow-up inoculations and advises that the form be taken to the physician and updated each time a vaccination or revaccination is administered.

Forms may be requested in quantity from local health departments or from the Division of Epidemiology, Maryland State Department of Health, 301 W Preston St, Baltimore, Md, 21201.

HEPATITIS

The Division of Epidemiology assisted in investigating an outbreak of infectious hepatitis in a development of some 70 families in the southern part of Harford County. The Public Health Service officer attached to the Division, with the help of county health nurses and sanitarians, made a complete census of the population, collected 140 blood specimens for liver function tests, gave gamma globulin to 160 household contacts, and inspected water supplies. Twenty-five persons gave a history of illness with jaundice in recent weeks; 16 persons gave a positive liver function test but no history of jaundice, and a sampling of the wells showed heavy contamination. The attack rate of 10% or more is unusually high.

Although the study is not finished, evidence points to the private water supplies as the possible vehicle of transmission. Residents with contaminated water supplies were advised to boil drinking water and were given instructions in starting procedures to disinfect the soil and destroy the bird roost.

HISTOPLASMA INFECTED SOIL FOUND IN BALTIMORE COUNTY

Soil in a six-acre wooded lot which had been used on a massive scale as a roost by starlings and grackles was found to be contaminated with the fungus, *Histoplasma capsulatum.* This could constitute a health hazard if children and pets play in the area or if the soil is disturbed. Preventive steps taken by health authorities include: quarantine of the area, notification of residents and students of nearby schools of the risk, plans to skin test students and residents of the area, a study of the nature of the soil infection, and starting procedures to disinfect the soil and destroy the bird roost.

PAYMENT FOR TISSUE SPECIMEN EXAMINATIONS

From 1949 to 1965, the Maryland Division of the American Cancer Society paid for the patho-



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logical examinations of tissue specimens from outpatients of health clinics unable to pay for these diagnostic services. Such payments were discontinued on September 1, 1965. Arrangements now have been made for the Department of Pathology of the University of Maryland Medical School to perform these examinations at a mutually satisfactory charge.

DAILY MAILING OF PKU SPECIMENS REQUESTED

It has been found that the mailing of PKU test specimens "within one week after collection" (as required by the Department's Regulations 43B02, effective August 1, 1965) is so late that confirmation of the diagnosis and initiation of treatment may not be in time to prevent serious mental retardation. A change from weekly to *daily* mailing of specimens has been requested. Specimens should be addressed to: Bureau of Laboratories, Maryland State Department of Health, 16 E. 23rd St., Baltimore, Md., 21218, Attention: Bioassay Laboratory.

Eleven cases have been discovered under the state's screening program of newborn infants.

THIRTY-EIGHTH PACKAGED HOSPITAL PLACED

A 1962 model packaged disaster hospital was pre-positioned in Port Deposit to augment the disaster capability of Cecil County. This 200-bed unit makes a total of 38 such units located in the state. Valued at $45,000, it is one of the 750 new hospitals being placed throughout the country by the Public Health Service. The Department's Office of Health Mobilization arranges for location and surveillance of packaged disaster hospitals in the state as one aspect of its program to assure the provision of essential health services in the event of a large scale disaster.

LEPROSY

A case of leprosy was reported through the Baltimore City Health Department. The patient was a young alien who had been in the area about 18 months. The diagnosis was made by a Baltimore dermatologist. The patient was hospitalized in Baltimore for three weeks and then sent to the Public Health Service Hospital at Carville.

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New Immunization-Birth Record Card

Recent studies by the Baltimore City Health Department indicate that the immunization level among preschool children in Baltimore ranks high compared with other large cities. To further improve this good record and to provide individuals with a permanent certificate of immunization, a "Birth Certificate Follow-up Plan" has been devised, which emphasizes the maintenance of proper immunizations throughout infancy and childhood.

Beginning this month, an IBM size *Notification of Basic Immunizations* card, in addition to explanatory material, is being sent to the parents of each newborn baby in Baltimore. Parents are urged to seek the care and counsel of a private physician, pediatrician, or clinic of their choice to provide immunizations for their new baby.

It is important for the success of this new program that this postage-paid immunization card be dated, signed, and returned to the City Health Department upon completion of the basic immunization series, which includes a series of three DPT and polio immunizations.

When the City Health Department receives the completed IBM form, it will send a permanent, wallet-size, plastic *Birth Registration—Immunization* card to the parent. On the reverse side of the card is space for the family physician to record future immunizations, including smallpox and measles. This card then becomes a valid immunization record which will be acceptable to school authorities when the child is ready to enter school.

DR. GLADUE APPOINTED

J. Raymond Gladue, MD, has been appointed to the staff of the City Health Department's Medical Care Section in the capacity of medical supervisor of nursing homes.

A native of Woonsocket, RI, Dr. Gladue received his medical degree at the University of Rochester in 1949. He served his residency at Baltimore City Hospitals and in 1953 became staff physician at the Veterans Administration Hospital in Baltimore. In 1960 he entered the practice of internal medicine, specializing in diseases of the chest. In addition to his private practice, he was medical director of Jenkins Memorial Hospital for chronic diseases, chief of Somatic Services at Springfield State Hospital, and medical consultant to the Social Security Administration's Disability Section.

In his new post, Dr. Gladue will be concerned with the placement of patients in nursing homes and improving their care. He will work closely with nursing home administrators and physicians.

DR. J. WILFRID DAVIS RETIRES

On October 31, after 22 years of service in the Baltimore City Health Department, J. Wilfrid Davis, MD, MPH, assistant commissioner of health, retired from his post as director of the Medical Care Section.

Dr. Davis's work in the Baltimore City Health Department began December 1, 1943, as director of the Bureau of Communicable Diseases. His rich experience in working with physicians in private practice earned their close cooperation and esteem. He rendered outstanding service in this position, which he held until 1948.

On June 2, 1948, he was appointed director of the City Health Department's Medical Care Sec-

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tion. In this capacity he built an efficient department which now serves more than 70,000 indigent persons and involves the services of 700 physicians, seven hospitals, and 500 pharmacies in providing medical care. The task was not easy because the provision of medical care for welfare clients under the auspices of the Health Department was a new service and not yet widely accepted in the United States. But through perseverance, Dr. Davis gave our city a medical care service which is one of the finest of its kind in the United States.

Medical Assistance to the Aged was added to his bureau's services on June 1, 1961. This program has grown until it now assists almost 9,000 elderly persons who are eligible for services.

Dr. Davis was born in Nova Scotia and received his early education in the public schools of that province and at Regina Normal School. For three years he served in the Canadian army, and most of this time was spent in Europe during World War I. In 1924, he received his medical degree from Dalhousie University, Halifax, Nova Scotia, and spent the next three years in private medical practice with part time service in county health work.

He began then to devote his energies to public health work. He attended the Rockefeller Foundation Public Health Field Training School in Mississippi in 1928. The following year he was appointed to the staff of the Kentucky State Board of Health as assistant director of the Bureau of County Health Work. Later he served as health officer of Fayette County and held an appointment on the medical staff of the University of Kentucky. Following this service he worked with the West Virginia State Health Department. From 1932 to 1937, Dr. Davis was field director for the W. K. Kellogg Foundation in Michigan.

Dr. Davis received the degree of Master of Public Health from the Johns Hopkins School of Hygiene and Public Health in 1937. He was director of the Marion County Health Department, in West Virginia, until he came to Baltimore in 1943. Throughout his years with the city, Dr. Davis has proven to be a capable administrator, a highly esteemed public servant and, perhaps above all, a humanitarian.

Robert E. Farber, MD
Commissioner of Health

STATE OF MARYLAND

Department of Mental Hyqiene

Patient Mortality

PER CENT DYING DURING 18 MONTH OBSERVATION PERIOD

		PATIENTS ADMITTED WITH A DIAGNOSIS OF		
Age (in years)	Total Maryland Population	Alcoholic Disorders	Psychotic Disorders	Psychoneurotic and Personality Disorders
25-34	0.2	1.7	0.5	1.1
35-44	0.5	4.1	1.6	2.6
45-54	1.2	7.5	4.6	2.4
Total	0.6	4.9	2.0	1.9

Mortality among patients in Maryland's mental hospitals has remained at a high level in recent years despite a gradual, continuing shift from a chronic, long term population to one admitted for acute, short term treatment services. Last year 1,002, or 9.3% of the patient population, died while hospitalized.

Related to this high rate is the large number of deaths within a short period after onset of hospitalization. One out of every seven deaths occurs during the first month after admission. It is apparent that many newly admitted patients, particularly the elderly, have major physical disabilities and illnesses, are poorly suited for mental hospital care, and should more appropriately be placed in nursing type facilities or in homes with medical and other supportive services.

However, mortality is high among patients regardless of whether death occurs while hospitalized or in the community after release. The table from a recent study* shows the per cent of some selected patient cohorts who died within 18 months after admission to the three major Maryland state mental hospitals. It should be noted that six out of 10 deaths occurred in the community after hospital release. Comparable figures for the total state population for an 18-month period were supplied by the Maryland Health Department.

Mortality in each diagnosis-age group was substantially higher than comparable rates for the general population. This disparity was particularly pronounced among alcoholic patients where death rates were at least six times greater than similar rates for the total Maryland population. Many psychiatric hospital patients come from poor, deprived population groups concentrated in inner city areas. Mortality here is known to be higher than for the state as a whole. However, this by itself cannot explain the much larger patient death rates. A number of questions remain unanswered, and further investigations are indicated:

1. Is there a significant difference in the life expectancy of mental patients and comparable general population cohorts?

*A Psychiatric Case Register Study Of Release And Return Rates For State Mental Hospital Patients, presented at the annual meeting of the American Public Health Association, October 18, 1965.



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2. Is there a significant difference in the life expectancy of similar age-diagnosis groups treated in public hospitals, private mental hospitals, and outpatient psychiatric facilities?

3. Are there any causes of death which contribute unduly to observed variations?

4. To what extent can mortality patterns among psychiatric patients be changed by closely coordinated community and hospital programs stressing the relationship of physical and mental illnesses?

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The New Patient

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I tried playing a little game the other week. Every time I met a physician, I asked him what he thought was the most important thing in welcoming new patients. The answers I got ran something like this:

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All well and good. Those things are fine for every person you serve. But what do you do that's *special* for the first-time patient in your office?

In a lot of ways, the new patient is a special creature. Unlike your regular patients, he doesn't know a thing about you—whether you're fast or slow, gentle or rough. But he'll learn quickly enough from your first few appointments.

Try these three suggestions on your new patients:

1. LET THE NEW PATIENT PICK THE INITIAL APPOINTMENT TIME. When he first calls, your assistant should ask him when he wants to come, not tell him when you can finally manage to squeeze him in.

This makes Mr. New feel pretty good. He thinks he can have any time he wants. Of course, he can't. If the time he picks is impossible, a sharp assistant can easily switch him to another spot. But she should try to accommodate him even if it means shifting some other appointments.

2. BE READY FOR YOUR APPOINTMENT ON TIME. Everyone runs behind on his schedule now and then. But when you have a new patient coming, make a special effort to be ready and waiting for him. Your assistant can put a star in front of his name in the appointment book as a reminder.

It's always nice to make your appointments on time, but it's doubly important with a new patient. He's got a problem but, unlike the patients you're already treating, he doesn't know how serious or expensive it's going to be. As he sits there in your waiting room, he's a troubled man. The longer he sits, the more troubled he becomes.

3. SCHEDULE SOME EXTRA TIME FOR THE NEW PATIENT, BEYOND WHAT YOU NEED FOR THE TREATMENT. This is the get acquainted period, the time when you and the patient get to know one another. It's vitally important.

When you are scheduling time for the initial appointment, don't schedule any others in your second examining room. Maybe you will "waste" five minutes waiting for an injection to take, but that's better than having the patient feel you deserted him for someone else.

All of this sounds like the new patient is getting the red carpet treatment. Indeed he is, and he likes it.

When he knows you and your office routine better, he'll come to understand that he can't have any appointment time he picks, that you're just human enough to run behind in your schedule, or that you sometimes step into another examining room to give an injection or make an adjustment. And it won't bother him at all.

One thing more: Every once in a while—just as often as your time permits—TRY TREATING YOUR OLD PATIENTS LIKE NEW PATIENTS. They'll love it!

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Visits to County Society Meetings

Among the most gratifying contacts developing in our library program recently have been the visits to several county society meetings. In all instances the members have shown a real interest in the books brought to these meetings and in learning of the services the library can furnish. County societies that wish library representatives to vist should let the librarian or Mr. Sargeant know so that a schedule can be arranged. This applies to requests for special subject material or titles the county members desire also.

BOOK REVIEWS

From time to time we shall feature book reviews in this column, beginning with the following by Frank L. Iber, MD, associate professor of medicine, Johns Hopkins Hospital.

MEDICAL, SURGICAL, AND GYNECOLOGIC COMPLICATIONS OF PREGNANCY, Second Edition. Edited by Joseph J. Rovinsky, MD, and Alan F. Guttmacher, MD. 843 pages. Waverly Press, Inc., Baltimore, 1965

Medical books, like doctors, have become more and more specialized in their material, so that it is rare indeed for a book to be of use and interest to ALL practicing physicians; yet I believe that this is such a book. Pregnancy is increasingly recognized in the presence of many acute and chronic diseases. Few of us, as physicians, are qualified by experience or training to answer the ever-present questions: What does the disease do to the pregnancy, the fetus, or labor? What do the pregnancy and labor do to the disease? What effect does the usual treatment of the disease have on the pregnancy, the fetus, or the conduct of labor?

Textbooks of obstetrics usually emphasize the first of these problems—the effect of the disease on the pregnancy, the fetus, and labor, but do not provide sufficient detail on the other questions. The Obstetrics Department of the Mount Sinai Hospital, in New York City, began some 15 years ago a series of special clinics in 10 areas of major disease to observe the course of pregnancy on varicose veins, heart disease, and other conditions. These clinics were staffed jointly by obstetricians and other specialists in the field of the clinic. From this emerged the first edition of this book, published in 1960, and the present volume.

The current edition consists of 56 chapters organized into 13 major subheadings. Each of the specialty areas contributes a section, thus covering cardiovascular-renal disease, pulmonary disease, gastrointestinal disease, eye, ear, nose, and throat problems, malignancy, neuropsychiatric problems, hematologic problems, endocrine, dermatological, infectious, and collagen diseases. Special detailed sections on some of the gynecologic, surgical, and obstetric complications that influence other diseases in a special way are presented.

Each chapter is written from the point of view of the physician managing the pregnant patient, emphasizing neither the obstetrician's nor the specialist's point of view. It draws upon special information from both fields and relies heavily on the experience of the writer and the literature.



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The information given is that which a psychiatrist, a gastroenterologist, or a surgeon expects himself to have, but from infrequency of encounter is often not immediately available. The present edition has special emphasis on the effect of therapeutic maneuvers on the pregnancy and fetus. Factors leading to the therapeutic termination of the pregnancy are widely discussed, and guidelines offered for all physicians.

The book is a most attractive package. Most chapters are readable and of a length suited for the busy physician. Additional reading is offered for those requiring more information, but most of the needed facts are given. The editors have exercised a heavy hand to maintain uniform conciseness.

Frank L. Iber, MD

RECENT ACCESSIONS

American Medical Association Conference on International Health, 2d, Chicago, October 1963.

American Medical Association Conference on Mental Retardation, American Medical Association, 1964.

American Medical Association: Council on Drugs. *New drugs, 1965.*

American Medical Association: Workshop on Biomedical Vocabulary Control. Proceedings, 1964.

Birch, Herbert G.: *A selective bibliography on brain-damaged children.* Woods Schools and Residential Treatment Center, 1964.

Drillien, Cecil M.: *The growth and development of the prematurely born infant.* Williams and Wilkins, 1964.

Garrod, Lawrence P.: *Some difficulties in the sterilization of surgical equipment.* Seton Hall College of Medicine and Dentistry, 1957.

Health Insurance Institute: *Health insurance and health care statistics,* 1965.

Health organizations of the United States and Canada: national, regional and state, Cornell University, 1965.

Heard, Joseph Norman: *Bookman's guide to Americana,* 3d ed. Scarecrow Press, 1964.

Kaiser, Frances E.: *Translators and translations: services and sources in science and technology.* Special Libraries Association, 1965.

Life insurance fact book, 1965.

The Merck veterinary manual. Merck, 1961.

Montagu, Ashley: *Life before birth.* New American Library, 1964.

National Conference on Disaster Medical Care: Proceedings, American Medical Association, 1964.

National Institutes of Health: *Research for health;* a report from the National Institutes of Health, 1964.

Oxorn, Harry: *Human labor and birth.* Appleton-Century-Crofts, 1964.

Sanford, Gilbert A.: *Hospital facilities and needs: Anne Arundel County. A study of hospital usage and needs, 1960-1980.* Hospital Council of Maryland, Inc., 1965.

U. S. Public Health Service: Division of Chronic Diseases. *Portraits in community health. Rural home nursing care for long-term illness.* Public Health Service, 1965.



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January, 1966

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Mrs. Howard Weeks

President, Woman's Auxiliary to the Washington County Medical Society

Buckannon, WVa, was the birthplace of Mrs. Weeks and her twin sister. Mrs. Weeks majored in home economics at the University of Maryland and did catering before her marriage. In 1948 the family moved to Hagerstown. There she met Dr. Howard Weeks, who was dating her twin sister. Five years later he decided he preferred the other twin and made her his wife.

Dr. Weeks had, in the meantime, graduated from the University of Maryland School of Medicine and interned at St. Vincent's, Bridgeport, Conn. After three months as a ship's surgeon with the Grace Lines, he began general practice in Hagerstown, where they have made their home.

Because of their hair coloring, the Weeks children liken themselves to three ice cream cones, each a different flavor: 9-year-old Renelle is strawberry, 7-year-old Howard, Jr., is vanilla, and 1-year-old Roxanne is chocolate.

Mrs. Weeks has held numerous offices and chairmanships in the Washington County Auxiliary. She has also served as finance chairman in the state auxiliary. In her community she is active in her church and in the ZONTA International.

Beginning with their honeymoon 10 years ago, Dr. and Mrs. Weeks have traveled extensively both in the United States and abroad. But since Dr. Weeks has become chief of staff at the Washington County Hospital, they will have to curtail their travels somewhat.

Culinary art is a hobby of Mrs. Weeks. She collects cookbooks and names *Gourmet* as her favorite magazine. At the end of a busy day, she often reads herself to sleep with one of these.



THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM

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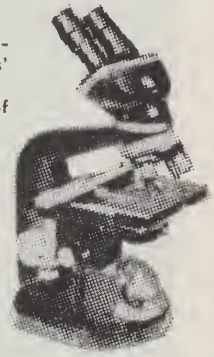
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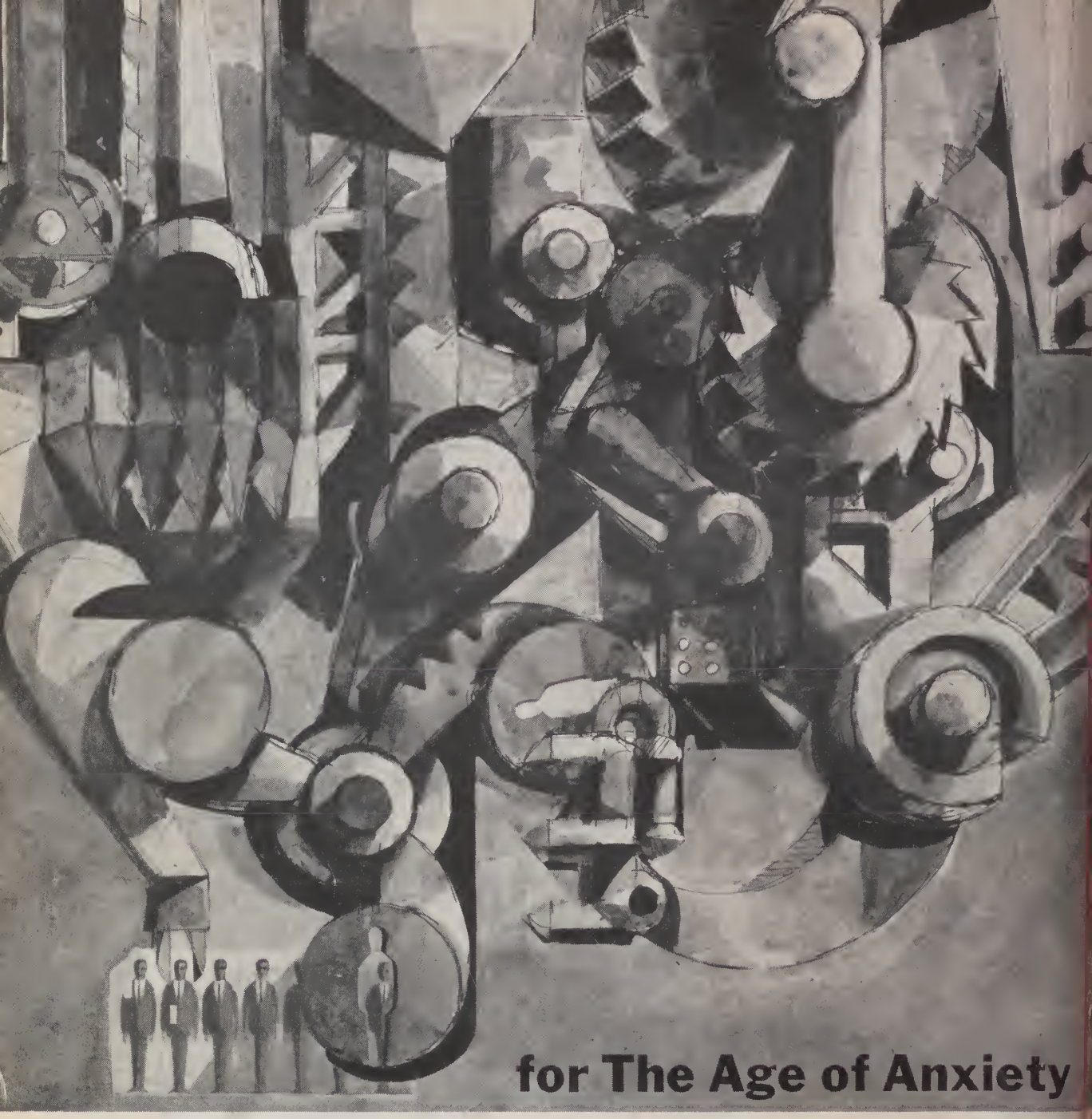
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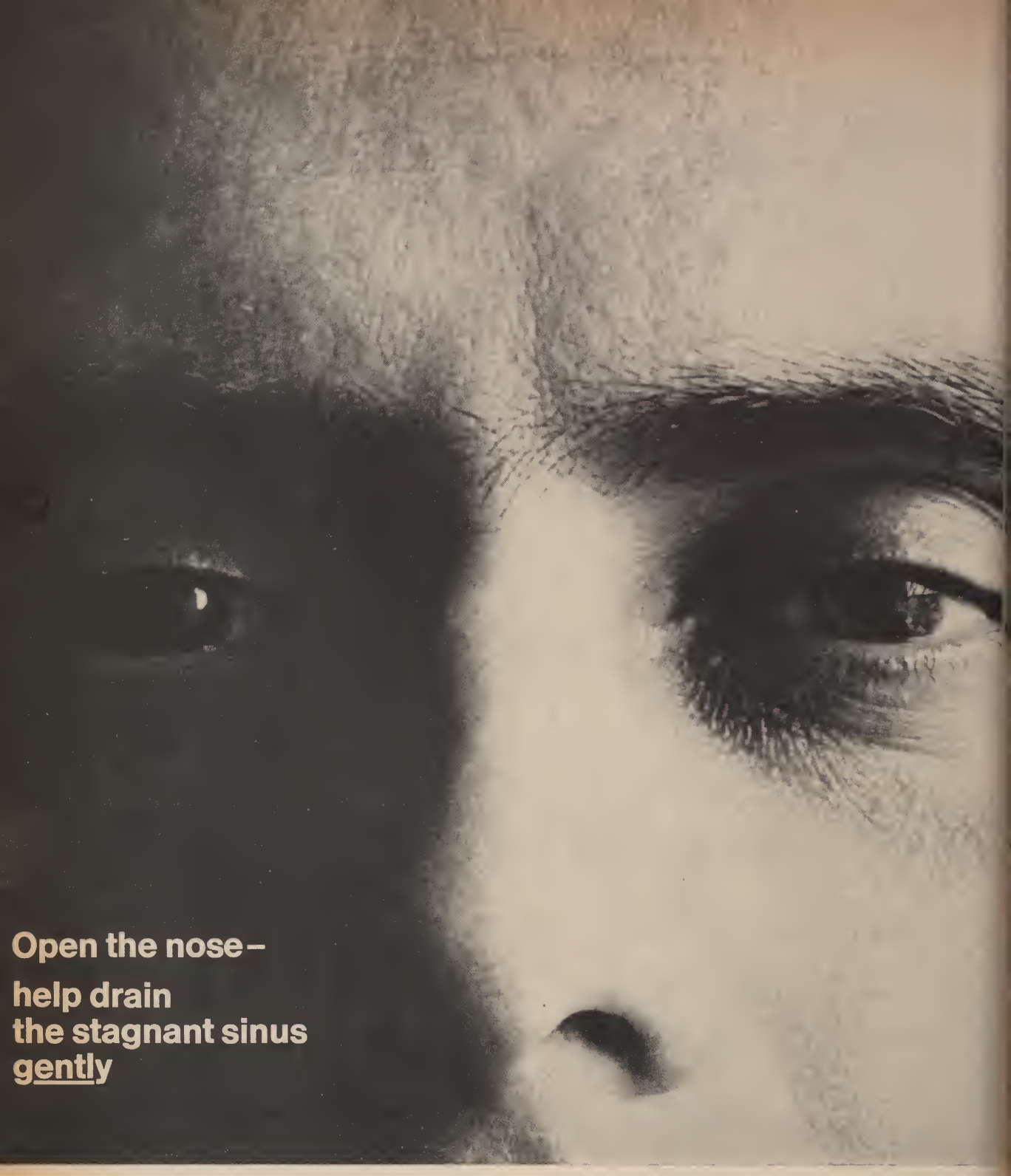


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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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Februory 25—1-2 PM

From Frederick Memoriol Hospitol: "Iron Metabolism," Major Marcel Conrad.

March 4—12:30-1:30 PM

From University Hospitol: "Diagnosis and Treotment of Tronsient Ischemic Attacks of the Brain," Erland Nelson, MD, and Alfred F. Heck, MD.

March 11—12:30-1:30 PM

From The Johns Hopkins Hospitol: "Cardiac Emergencies," Richord S. Ross, MD.

March 25—1-2 PM

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March 8—8 PM—1211 Cathedral St., Baltimore

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UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

March 8—11:30 AM—Gordon Wilson Hall, University Hospital

Twenty-first annual Aaron Brown Lecture, jointly sponsored by Phi Delto Epsilon Froternity and Department of Medicine, University of Maryland School of Medicine. "Primory Hypertension: Epidemiology and Epilogue," George A. Perera, MD, associate dean and professor of medicine, Columbio University College of Physicions ond Surgeons.

MARYLAND PSYCHIATRIC SOCIETY

March 10—8:30 PM—1211 Cathedral St., Baltimore

Joint meeting with the Marylond Association of Private Procticing Psychiatrists. Wendell Muncie Award-winning poper to be onnounced and presented.

March 10-11—Sheraton Hotel, Philadelphia

HEART ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA

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March 11

HEART ASSOCIATION OF THE LOWER EASTERN SHORE

Teaching sessions for physicians: "Hypertension," Donald Wolfel, MD.

March 12—8:15 PM—Goucher College

THEATRE PARTY

Sponsored by Women's Auxiliary to the Baltimore City Medical Society. See pages 111-112 for more information.

March 15—7:30 PM—1211 Cathedral St., Baltimore

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

"General Anesthesia in Outpatient Dentistry," Mary Lou Barker, MD, Washington, DC.

March 22—Sheraton Belvedere Hotel, Baltimore

MARYLAND EAR, NOSE AND THROAT SOCIETY

6:30 PM—Cocktails and Dinner

8 PM—"Epistoxis With Particular Reference to Ligation," J. Ryan Chandler, Jr., MD, professor of otolaryngology, University of Miami Medical School.

March 26-27—Marriott Motor Hotel, Philadelphia

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Fifth Annual Colloquium for Post-Graduate Teaching of Psychiatry will attempt to provide an opportunity for interchange of ideas about experiences with the post-graduate teaching of psychiatry to non-psychiotric physicians. The program will emphosize small group discussions. As a background for these discussions, two formal presentations will be made. The first, a panel consisting of Mr. Lee Isenberg and Drs. John E. Donnelly, Stephen Fleck, and Austin McCawley, will discuss the educational approaches of the Connecticut Academy of General Practice, with emphasis on their successful recruitment program. The second, a talk by James N. Mosel, will deal with practical aspects of the learning process.

Sunday afternoons—2 PM—WMAR-TV, Channel 2

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March 6—"Pep Pills and Tranquilizers"

March 13—"Psychiatry"

March 20—"Allergies"

March 27—General Medical Panel

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8. OBSTETRICS—February 10

Under direction of Edmund B. Middleton, MD: Problems of obstetrical management in the prenatal period and at the time of delivery will be considered.

9. HEMATOLOGY—March 10

Under direction of Carroll L. Spurling, MD: A basic review of diseases of the hemopoietic system. Illustrative peripheral blood and bone marrow slides will be used in connection with selected case material. Newer techniques of diagnosis and treatment will be discussed.

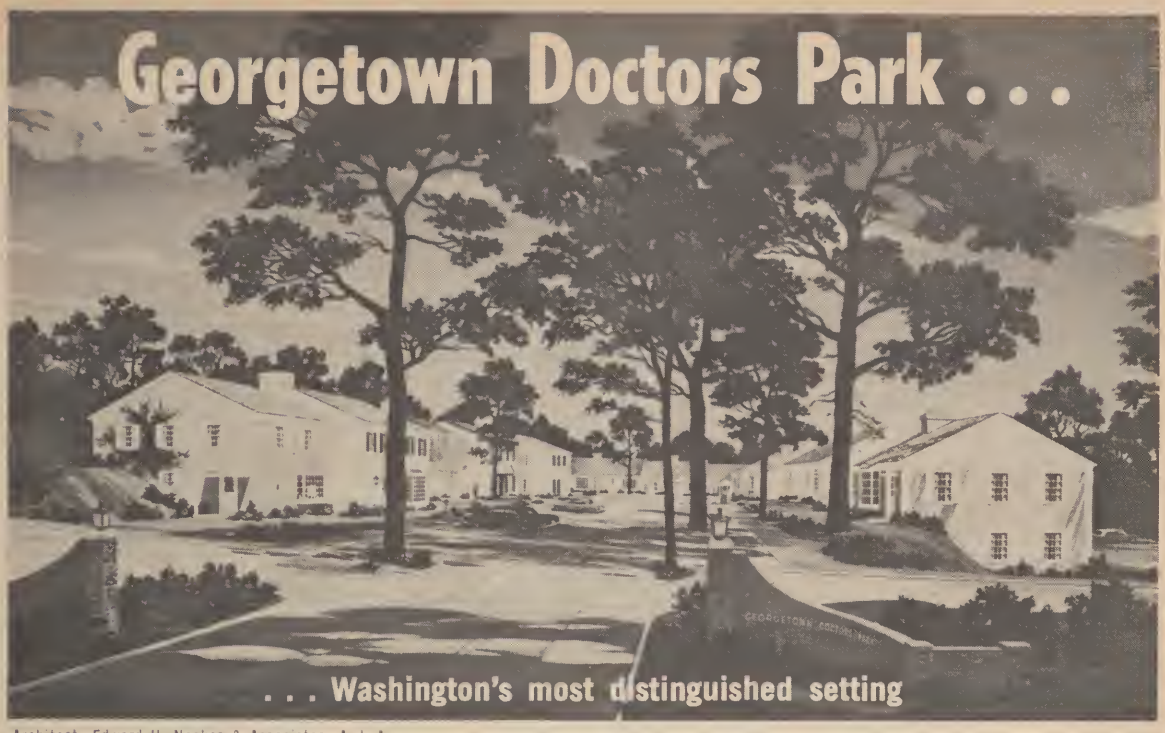
AMERICAN COLLEGE OF PHYSICIANS

Course No. 13—THE BIG HEART, March 7-11, Baylor University College of Medicine.

Course No. 14—BASIC MECHANISMS IN INTERNAL MEDICINE, March 28-April 1, University of Toronto.

Course No. 15—CURRENT CONCEPTS OF RENAL, GASTROINTESTINAL, AND CIRCULATION PHYSIOLOGY, April 14-16, Barbizon-Plaza Hotel, New York.

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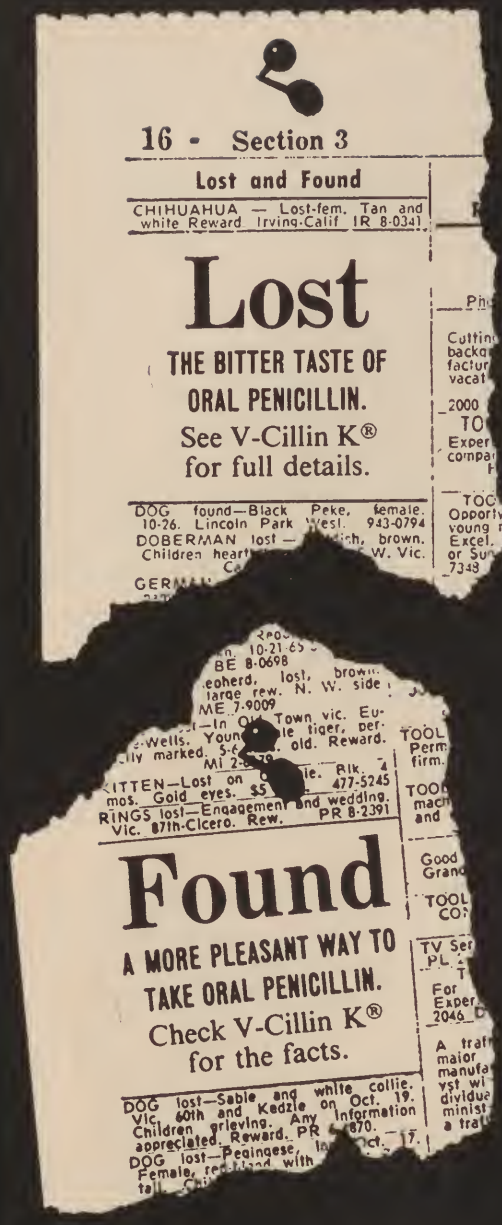
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Maryland State Medical Journal
Vol. 15, No. 2
February, 1966

Editorial

MORE ABOUT THE EDUCATED HAND

SAMUEL MORRISON, MD
Past President, Baltimore City Medical Society

A recent editorial (October, 1965) considered the educated hand as a diagnostic instrument. The gratifying response to this editorial leads me to comment further on the educated hand.

To the gynecologist, the educated hand is his most important examining tool. Dr. Imre Neubauer told me that in one of the European hospitals devoted to gynecology there is a picture of the gynecologist's hand, and on one of the fingers is an eye, indicating that with his hand he sees.

The hand is also an instrument for treatment. Consider the dextrous and skillful hands of the surgeon or the even more delicate hands of the ophthalmologist when he performs his fine operations.

It is a wonder of the Creator that these remarkable hands, so often taken for granted except when they are lost or injured, can perform such diverse functions. The alert, running fingers of the skilled typist are impressive to behold, as are the deft hands of the pianist. The tender and expressive hands of the ballet dancer are unequaled in beauty. The reading hands of the blind are amazing evidence of the ability of the hand to see and interpret. The hypnotic hands of the magician seem to defy the impossible.

We have seen people who have lost their hands or had them maimed, and we marvel at the mechanical attempts to replace them. Yet though they approximate the human hand, they can never equal the original.

In medicine, the sensitivity of the physician's hand can be impaired. This might happen when he presses too hard, not only pushing away the object which he is trying to examine but also compressing his own fingertips or hands, diminishing the blood supply, and rendering the examining hand less sensitive, less able to react reflexly, and less able to interpret.

It seems to me that the proper use of the hand reaches a peak in our profession. In the overall picture it should not be compared to the eyes or the ears, which have other remarkable properties, but it can be compared to a God-given instrument with all the complex abilities of a human being. Without question, the educated hand is among the most valuable of our tools for both diagnosis and treatment.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, DECEMBER 9

1. One staff member was authorized to attend the meetings of the Professional Conventional Management Association and the Medical Exhibitors Association January 3-5, 1966.

2. Authorization was given for the annual staff Christmas party.

3. Authorization was given to close the Faculty building on December 24 and December 31.

4. Plans are nearly complete for the formation of a group concerned with area-wide health facilities planning. Since funds may be requested from all participating groups, this item was referred to the Treasurer to consider when compiling the 1966 budget.

5. J. Roy Guyther, MD, and William Pillsbury, MD, were designated Faculty representatives to an AMA Conference on federal-state programs for children and the medical aspects of the war on poverty (Title XIX of PL 89-97).

6. Various aspects of the new governmental programs were discussed with representatives of the State Health Department:

A. Former MAA patients will continue under Title XIX, as they were under the Kerr-Mills formula, for the fiscal 1967 budget. Consideration is being given to a switch in the fiscal 1968 budget so that the State Health Department may purchase the $3 a month supplemental program if it is deemed possible. This means that the present program for MAA patients will continue as is.

B. The question of reasonable or customary fees for medical care programs is currently under study in the Health Department, and further data will be available. The 1967 budget does not include funds for payment of such fees. It is hoped that this can be included in the 1968 budget.

C. No data have been received from HEW in connection with Utilization Committee activities, and no specific programs or activities in this area are contemplated at present.

D. The Health Department still has under consideration publication of a list of rules and regulations with which physicians must comply. It is hoped this will be available for distribution to physicians in the near future.

E. The question of volume drug discounts is under study in the Council on Medical Care. This would provide volume discounts in the form of a rebate to the state government on medical care prescriptions filled at the retail rate allowed under the medical care programs. Statistical sampling would provide the basis for making the discounts, and the discount would be based on the total amount of sales made to the State of

Maryland, including the individual Rx items.

F. A request is being processed for a planning grant under PL 89-239, the bill for regional programs of heart disease, cancer, and stroke. If a grant is approved, the medical society will be consulted and represented on the advisory committee to this program.

7. A request from Aetna Insurance Company to be designated by the Faculty as a candidate for fiscal administrator of the Medicare program could not be acted upon because it is a matter for Council action and the Council would not meet again until after the deadline for submitting suggested candidates.

8. Maryland Medical Service, Inc., presented the idea of a prevailing fee concept. The Executive Committee urges all physicians to cooperate with Blue Shield in a survey designed to establish guides for preparing a prevailing fee program.

9. Edmund G. Beacham, MD, was approved as the Faculty's candidate to receive the Governor's award for employment of the physically handicapped.

10. The question of statewide or regional sessions to educate physicians and their staff on PL 89-97 (Medicare) was referred to the Policy and Planning Committee.

11. Approval was given to co-sponsoring a conference on traffic safety with the Maryland Chapter, American College of Surgeons.

12. Because of a conflict with Faculty policy, the Executive Committee could not endorse the Provident Hospital's fund campaign. This must be left to the individual physician to decide.

13. An informal presentation was made of the survey on "Patterns of Medical Care." This project will be cleared through the Policy and Planning Committee and recommendation made to the Council.

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Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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EXECUTIVE SECRETARY'S NEWSLETTER

February, 1966

REFERENCE COMMITTEE MEETING SET

The Reference Committee meeting date has been set for

THURSDAY, MARCH 31, at 8:00 p.m.

at the Faculty Building. As of this writing, no resolutions have been received for consideration at this time.

Resolutions must be received in the Faculty Office by Tuesday, March 1, in order to be considered at the Annual Meeting, April 27.

CRUISE RESERVATIONS

March 1 has also been established as the date when reservatious for the Annual Meeting Cruise will be opened to other interested groups, rather than the Faculty.

Reservations should be addressed to:

Travel Guide Agency
416 North Charles Street
Baltimore, Maryland 21201
Telephone: 727-0682 or 727-1696

Miss Natalie Kuff is handling all arrangements in this area, on behalf of the Faculty.

NEWS NOTES

Gilbert D. Barkin, M.D., Silver Spring, has been named Secretary of the Southern Medical Association Section on Allergy.

Victor A. McKusick, M.D., Chief, Division of Medical Genetics and Professor of Medicine, Johns Hopkins University School of Medicine; and James Shannon, M.D., Director, NIH, Bethesda, have been granted Modern Medicine Distinguished Achievement Awards.

R. Donald Eney, M.D., and Eugene Goldstein, M.D., both of Baltimore, were certified by the Subspecialty Board in Pediatric Allergy, after passing examinations given last October.

Jacob H. Conn, M.D., Assistant Professor of Psychiatry at Johns Hopkins was honored at a testimonial dinner given on the occasion of his

62nd birthday, as well as 35 years in psychiatry and 25 years in medical hypnosis. The dinner was sponsored by the Society for Clinical and Experimental Hypnosis.

William O. Harrison, University of Maryland School of Medicine; and James L. Boyer, Philip O. Littleford, Robert M. Marshall and Bradley M. Rodgers, all of Johns Hopkins School of Medicine; are participants in the Smith, Kline and French Foreign Fellowships program. The program provides for medical students to assist physicians working in foreign fields and developing nations treat their sick people.

Frank J. Ayd, Jr., M.D., is editor and publisher of a newly established Newsletter, International Drug Therapy Newsletter.

NEW DRUG RULES

Several questions have been raised with respect to physician accounting for drug samples when they fall within the area of amphetamines and/or barbiturates.

Information is that:

1. Physicians who dispense drugs for which they charge the patient must maintain records of samples received in the mail or from the detail men.

2. Physicians who do not dispense will not have to keep records of samples received, used, or dispensed in the course of their practice.

Manufacturers, distributors and their representatives must keep records of samples given to physicians. See page 20 for further details.

MEDICAL EDUCATIONAL DEDICATED INSTRUCTION CHANNEL

Regular educational programs now in the fifth month of operation are attracting many listeners. University of Maryland Medical School has been added to the circuit.

Information on forthcoming programs and speakers can be found on page 7.

John Sargeant

Executive Secretary

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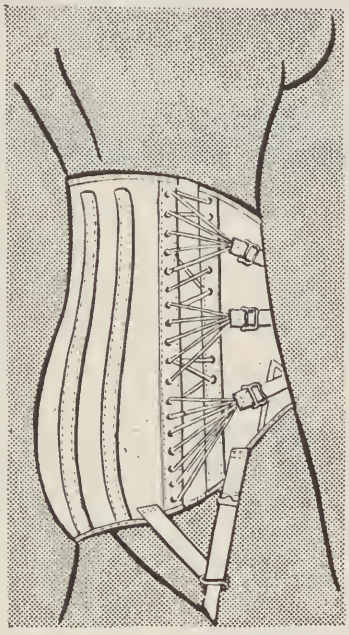
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PL 89-74 Now in Effect:

What Records Must Physicians Keep?

PL 89-74, which took effect February 1, establishes special controls over the manufacture and distribution of depressant and stimulant drugs. Among these controls is the keeping of records of the manufacture, sale, delivery, and receipt of such drugs.

To clarify the new law as it applies to physicians and the records they must keep, PL 89-74 clearly says that *physicians are not required to keep records as a consequence of this law unless, in the course of their practice, they dispense the drugs referred to and charge for them.* That portion of the act reads as follows:

> The provisions of paragraphs (1, Records) and (2, Inspection) of this subsection shall not apply to a licensed practitioner . . . with respect to any depressant or stimulant drug received, prepared, processed, administered, or dispensed by him in the course of his professional practice, unless such practitioner regularly engaged in dispensing any such drug or drugs to his patients for which they are charged, either separately or together with charges for other professional services.

The key phrases in this paragraph are the words *regularly engaged* and *for which they are charged.*

Further in this regard is a quote from the House Report of the Committee on Interstate and Foreign Commerce on HR 2, which became PL 89-74:

> The committee intends . . . to require record-keeping and to permit inspection in the case of those physicians who maintain a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients for a fee.

The language of the Senate Committee Report is identical. Both committee reports stated that those required to keep records "involve only a very small percentage of physicians."

The proposed regulations underscore this point, indicating that ". . . maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

For those physicians who, in the course of their practice, *regularly dispense drugs and charge for them,* certain records are required to be kept for three years, effective February 1, 1966. Included are: a complete, accurate record of all depressant and stimulant drugs on hand February 1, 1966; a complete, accurate record of the kind and quantity of each drug received, sold, delivered or otherwise disposed of; the name, address (and registration number under Section 510 ((e)) of FDCA) of the person from whom the drugs were received, and to whom they were sold, delivered, dispensed or otherwise disposed of; and the date of the transaction. No separate form for these records will be required as long as the information specified is available.

Gout is a chronic disease with a high familial incidence. The pathogenesis of hyperuricemia in patients with gout is still undetermined. Probenecid and colchicine have been effectively used for many years in moderate and severe cases of gout. A recently introduced anti-gout drug, a xanthine oxidase inhibitor, appears to have merit in resistant cases.

Selected Aspects of GOUT AND GOUTY ARTHRITIS

JOHN H. TALBOTT, MD, Editor
Journal of the American Medical Association

Gout is one of the diseases most gratifying to treat, and I am sure there must be one or two members of this group afflicted with the malady. Usually they are aware of it; sometimes not. It is a disease we see in physicians, among other groups of the social order.

We are dealing with a chronic disease, a disease once the diagnosis is made or once the clinical manifestations have appeared will be with the patient so long as he is with us. This means, then, that continuous attention must be paid to medication. It is not a disease that once the diagnosis is made, at least in most patients, it can be forgotten. When it is forgotten, then the patient sooner or later is a candidate for more and more trouble.

The malady has a higher family incidence than we are taught to expect. The longer we follow the patients, the higher the familial incidence in our experience. Gout may skip a generation, but the concentration of uric acid may be elevated into the gouty range in non-affected relatives. The several series that have been reported over a period of time reveal a familial incidence as high as 20% in the elevation of uric acid unrelated to acute attacks, or possibly, I should say, before the acute attacks.

It is proper to inquire in a long-range study, what is the chance of a non-affected relative becoming a patient at some future time? In our experience, which extends over more than two decades, the number of non-affected relatives, either male or female, who showed an increased concentration of uric acid without the development of acute articular symptoms is so low that it probably may be ignored except by the subject himself, who should be aware of the increased concentration. And at some future time, which may be 10, 20, 30, or more years, he may have an "unexplained attack of acute arthritis" unless he recalls this finding.

The changes in the serum uric concentration of a son of a patient with gout over a 12-year period are shown in fig. 1. We saw the son first when he was 10 years of age. The concentration of serum uric acid was quite within the normal range—3.8mg/100ml. The son came to see us

Presented at the annual meeting of the Medical and Chirurgical Faculty of Maryland, April 23, 1965, in Baltimore.

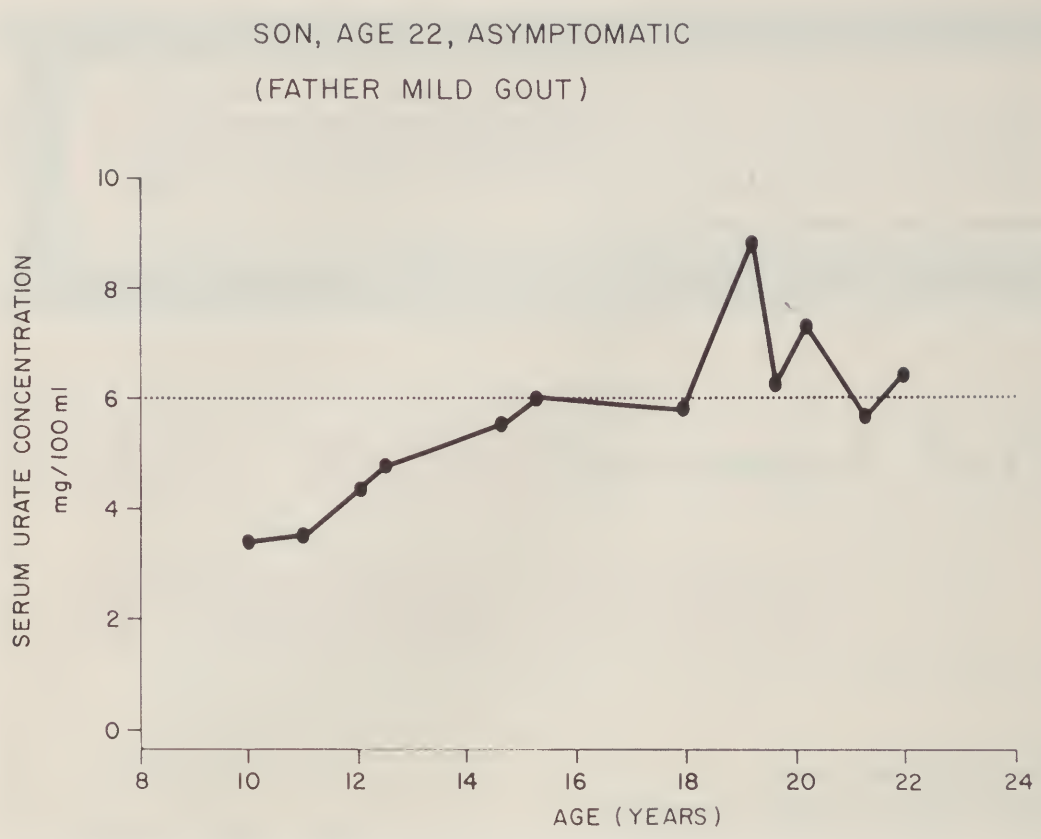


Fig. 1

from time to time according to a mutual understanding. Six years later, we noticed his serum urate had proceeded from the mid normal range to the upper limits of normal, 6mg/100 ml. As we followed him in the subsequent two or three years, he moved into the well developed gouty range, again without any symptoms of an acute attack of gouty arthritis.

We have two or three other examples in which there is good evidence that the increased concentration of uric acid in nonaffected relatives occurs during adolescence. Furthermore, we have examined a number of children below the age of 10 or 12 of gouty parents with normal concentrations and a number of non-affected relatives in the early 20's who show an elevated concentration.

The pathogenesis of the increased concentration of uric acid in the serum is still undetermined. There are three obvious reasons why there might be an increased concentration: a) too much being made by the body; b) too little being excreted by the kidneys; and c) too little being destroyed in the intermediary metabolism of the degradation product.

Some highly competent and devoted investigators believe there may be more than one type of clinical familial gout. This poses an interesting problem insofar as the pathogenesis of a disease generally. I am not one who believes there may be several disturbances in either the metabolism or the physiology of uric acid responsible for different types of disease. We see a great variety of clinical manifestations; those who have it in a very mild degree, who may have one attack every 10 years, or who may have one or two attacks in a lifetime, to those who constitute a relatively small percentage of the total who have severe chronic tophaceous gout. However, I believe it is all one disease, with varying impact on the patient.

We possess somewhat more evidence regarding the pathogenesis of the acute attacks. There is strong presumptive evidence that an acute attack of gout does not occur without the presence of uric acid crystals in the joint. On the other hand,

we see patients with extensive tophaceous deposits in the joints without any history of having experienced acute symptoms in the joint under consideration.

Why do the symptoms appear rapidly? We know that sometimes there are acute precipitating agents; parenteral injection of penicillin may be followed within a day or so by an acute attack of gouty arthritis in the susceptible person who is not protected by prophylactic medication. It has been recognized for several decades that gout may appear two or three days after a surgical procedure in patients not protected with prophylactic medication. Emotional trauma may be implicated as a precipitating factor. But we know also or have strong presumptive evidence that the uric acid has been present in the joint for a long, long time.

But why, when it has been deposited in a joint for so long, do such extraneous factors or factors that apparently are unrelated to acute articular distress cause the acute attack? We have a 20-year follow-up on such a patient. We had good evidence that neither knee gave the patient any trouble from attacks of acute arthritis. The first 10 years he was not protected with gout drugs, while during the recent 10 years, he was protected with colchicine. Other joints besides his knee were involved. In such a patient, without the administration of prophylactic medication, why does something happen at some time in which an acute arthritis develops while the urate deposits have been present for a long, long time?

The most reliable criterion in diagnosis is the evidence related to the clinical description. If I had one criterion only upon which to make a diagnosis, it would be the clinical characteristics of the acute attack. The incidence ratio remains 20 to 1, male over female. The age is also of some help. It is unusual to observe acute arthritis developing for the first time in the teens, although a few examples have been reported. At the other end of the scale, gouty arthritis may develop for the first time in the seventh or eighth decade. In most instances, it appears in the middle decades of life. The clinical characteristics are more helpful in diagnosis than the concentration of serum uric acid.

The second most helpful criterion is the response to colchicine. While a number of drugs are useful in the treatment of this disease, colchicine is the only specific drug. Except for two unusual manifestations of articular disturbance—sarcoidosis and a peculiar form of intra-articular calcinosis—colchicine is specific for an acute attack of gouty arthritis when administered in the accepted fashion; namely, regular administration, hourly or two-hourly intervals until the onset of gastrointestinal distress.

The other anti-articular agents—phenylbutazone, the steroids, ACTH, even aspirin may be of value in the treatment of many types of acute joint distress, but colchicine is the only specific drug for acute articular gout.

Determination of uric acid in the serum poses no problem in a laboratory deeply devoted to the study of this problem, where great reliance in a series of patients suffering from all types of joint disease are under study; but in the routine chemical laboratory, the serum uric acid determination is still one of the more difficult tests to perform and therefore is more susceptible to false interpretation. The average patient with gout, irrespective of the presence of acute or chronic symptoms, except for the administration of uricosuric agents, will show an elevation above 6mg/100ml.

On the other hand, many times when a patient consults the physician for the first time or consults the physician without a diagnosis of gout having been made previously, having had acute articular symptoms, may have well relied upon an aspirin-containing pain-reliever from the medicine cabinet, which drug tends to depress the concentration of uric acid. Thus, the result reported may have been unreliable if the datum is sought for diagnostic purposes.

If the uric acid is greater than 10 or 11mg/100ml, one must suspect a form of gout other than acute familial gout, such as a blood dyscrasia, particularly in a young person. Several drugs are known to cause an increased concentration of uric acid. The thiazide diuretics are the most common. Sometimes it is futile to speculate whether a patient on a thiazide is experiencing the first attack in an unrecognized family history or whether this is idiopathic gout related specifically to the administration of the diuretic. Treatment is the same irrespective of whether it is familial gout or gout associated with blood dyscrasia, or iatrogenic gout associated with the administration of a new drug.

When a patient is seen during the first attack,

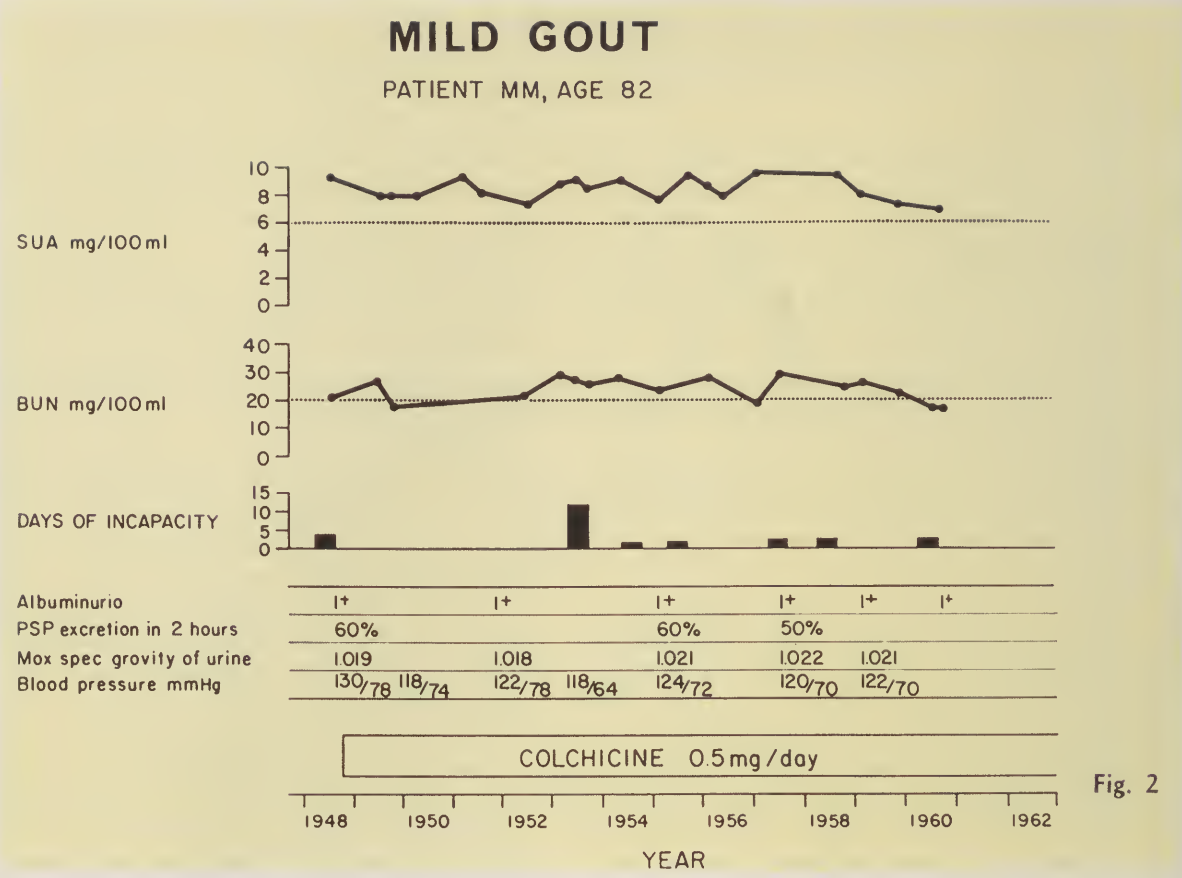


Fig. 2

it is helpful to have an x-ray, but we should not expect it to be positive. It should be procured for its documentary value or possibly to point to some other disturbance masquerading as acute gouty arthritis.

A positive family history is helpful in diagnosis. The presence of urinary findings and elevated blood pressure may be of some assistance. Approximately 40% of the patients with clinical familial gout will have intermittent or sometimes persistent unexplained albuminuria until a diagnosis of gout is suspected. A similar incidence holds for an elevation of blood pressure.

Renal disease is the only serious complication in our gouty series. Less than 15% of the patients with gout will die prematurely because of acute renal failure. With the availability of adequate drugs for use during the prophylactic period, this percentage should decrease decade by decade.

In a series of more than 200 postmortem protocols there were few kidneys, irrespective of the clinical severity of gouty arthritis, that were passed as normal. Most of the kidneys in this series of cases showed uric acid deposits of varying sizes. There were two other complications observed postmortem that were not regularly recognized clinically, ie, infection in the kidney and small vessel changes.

Figure 2 shows findings from a patient who was seen in his late 60's and was 82 at his follow-up, two years ago. Throughout the period of observation the blood urea nitrogen was either in the upper limit of normal, assuming 20mg/100 ml to be the upper limit of normal, or slightly above in one or two instances. If we saw such a patient who was not suffering from gout, who came to us suspected of suffering from other malady, with a persistent albuminuria and a blood urea nitrogen in this range, we would be concerned and deeply so in view of a poor ultimate prognosis. This patient, however, continues to do well. He has received only 1 mg of colchicine per day. You will recall that he is suffering from mild gout only, and this is a proper prophylactic dose for a patient with mild gout. When he was seen first in 1949, probenecid or other effective

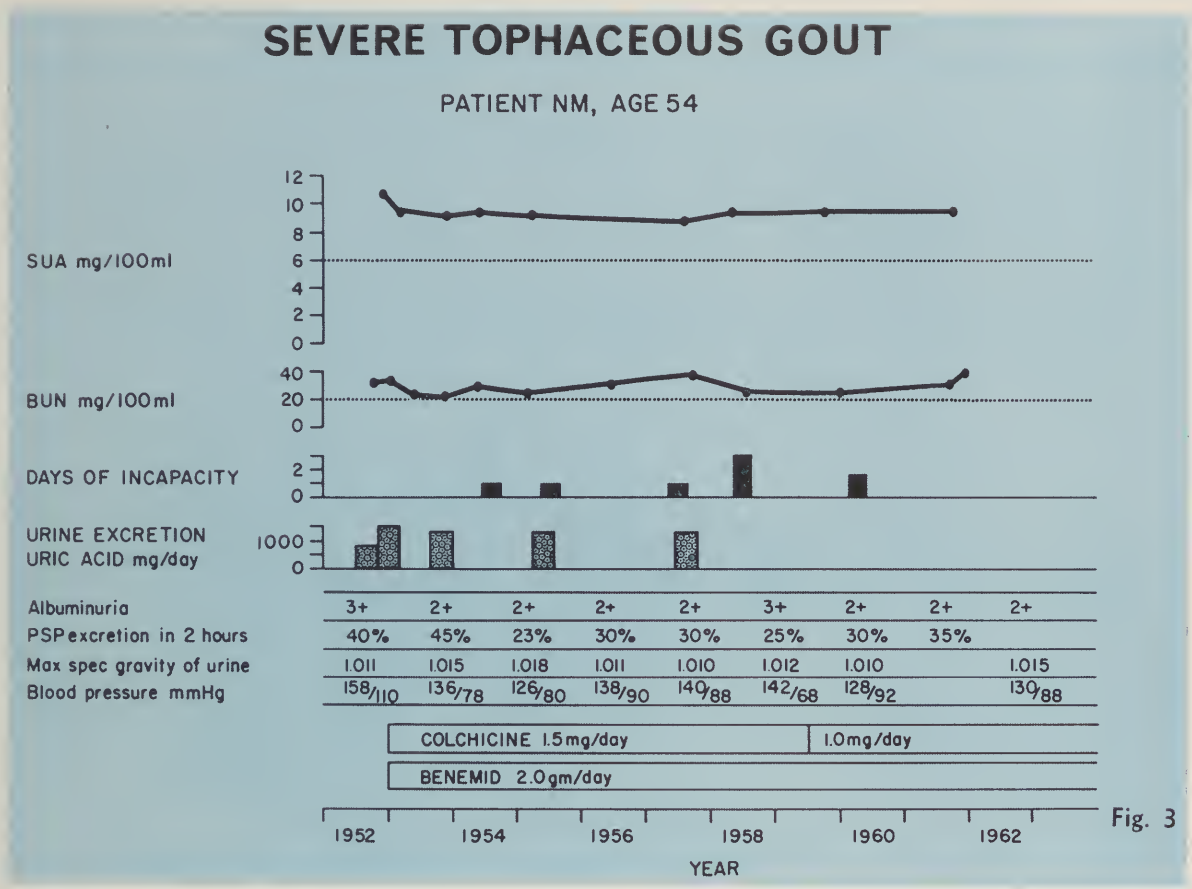


Fig. 3

uricosuric agents were yet to be discovered. During the 15-year period he has averaged not more than two days per year of incapacity. The blood urea nitrogen, a transient albuminuria, and some decrease in PSP excretion should give us some concern if the diagnosis were not gout. The maximum specific gravity of his urine on several occasions has been in the normal range with no elevation of his blood pressure.

Figure 3 shows our findings from a patient who presents a more serious problem. He suffered from severe tophaceous gout when seen in his middle 40's. His tophi had not increased in size during this 10-year-period, but his blood urea nitrogen has been as high as 40mg/100ml. It was never recorded below 20mg, which presents a greater prognostic problem. Albuminuria was 2 to 3 plus and persistent, while the PSP excretion was depressed. The specific gravity was fixed at most examinations. A light elevation of blood pressure gave no concern. Because of severe tophaceous gout, he was given four tablets of probenecid (2Gm) and three tablets of colchicine (1.5mg) a day and has taken this quantity during the 12-year period. He continues to do well, having no more than one attack every second or third year.

The patient whose data are shown in fig. 4 died after he had been observed for a short period of time. He represents quite a different clinical picture. He suffered from severe tophaceous gout at a relatively young age. His serum uric acid was mildly responsive to probenecid. His blood urea nitrogen was in the 40-50mg/100ml range. He experienced little incapacity from his gout because of the daily administration of probenecid and colchicine. Before our observations he had suffered greatly and had been forced to stay home, some years for several weeks. He had an albuminuria of 1 to 2 plus. His PSP excretion was essentially zero. The maximum specific gravity of the urine was less than 1.012. The blood pressure was normal. He died in renal insufficiency.

Figure 5 represents a relative of a gouty patient. His father, with mild gout, died of coro-

SEVERE TOPHACEOUS GOUT

PATIENT WM, ONSET OF GOUT AGE 29

DIED AGE 44

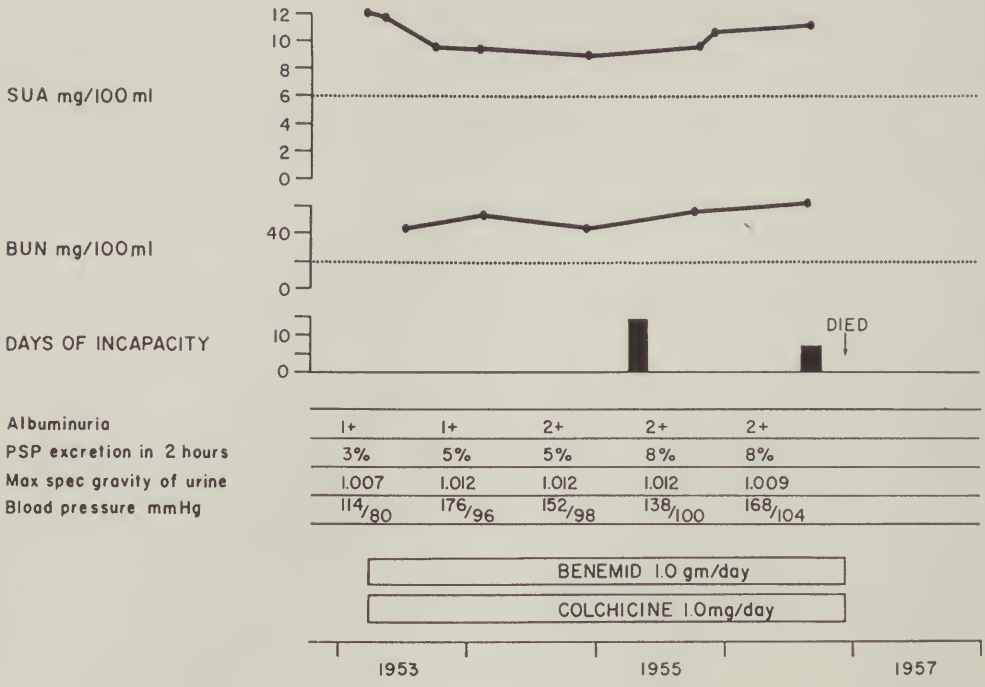


Fig. 4

FAMILY HISTORY OF GOUT

Persistent Albuminuria, Hyperuricemia

PATIENT H E

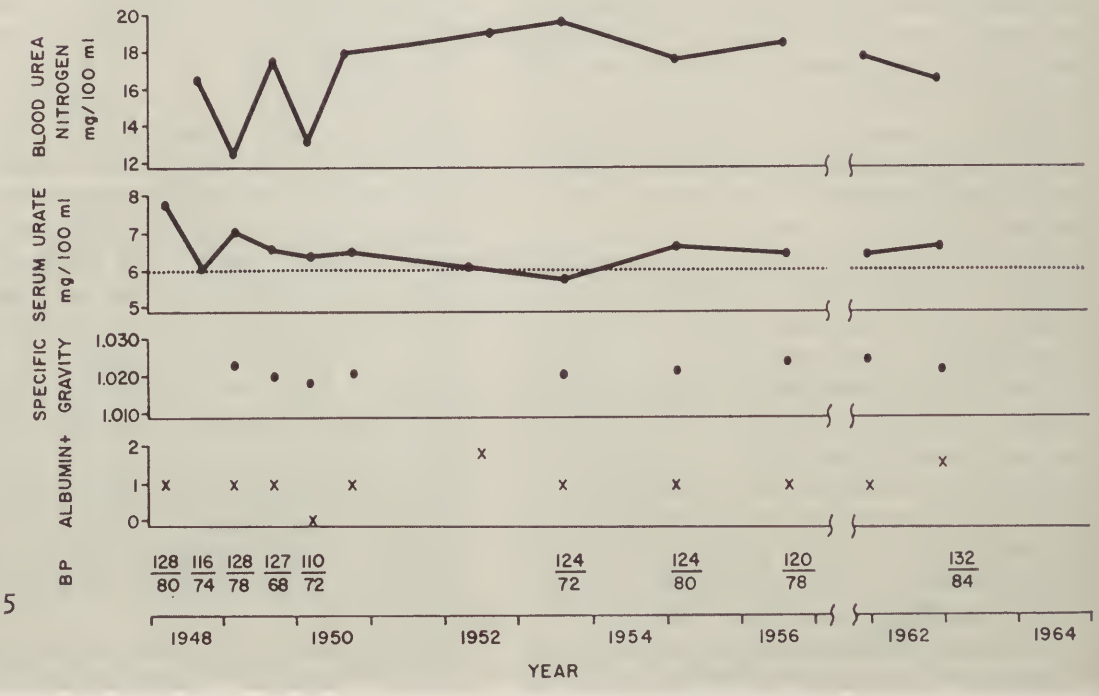


Fig. 5

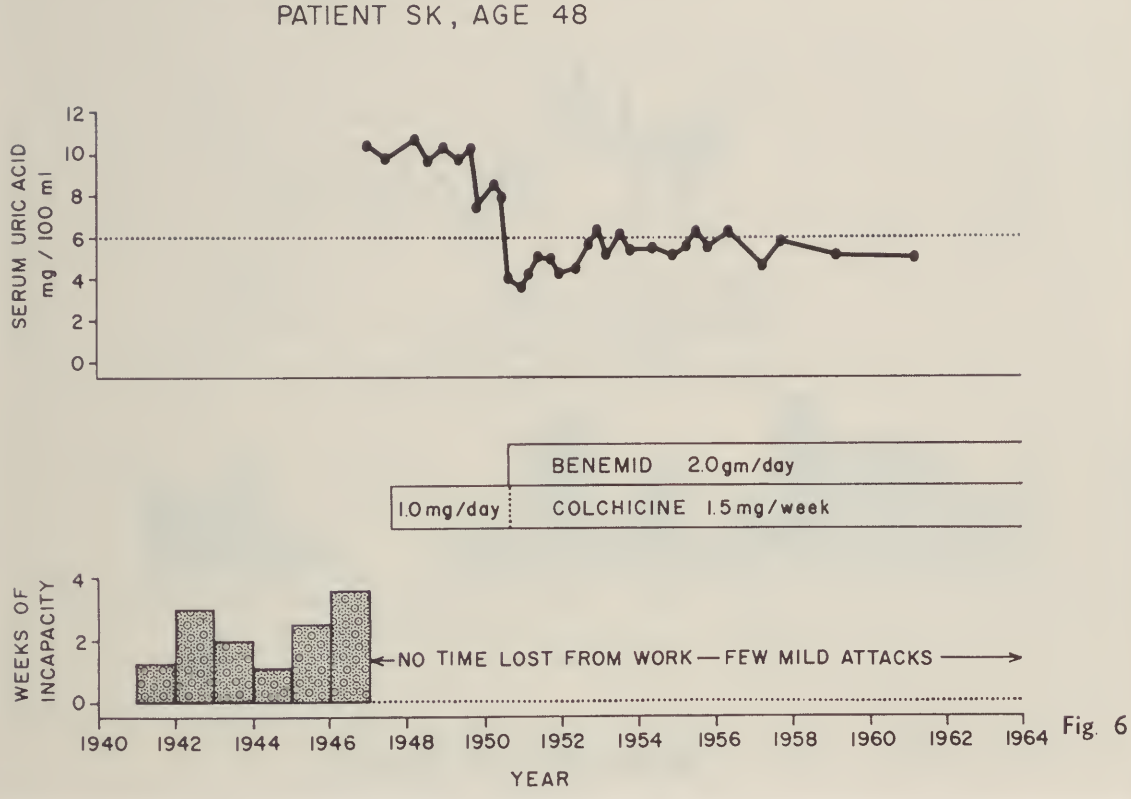


Fig. 6

nary disease in his mid 70's. We examined all the children and several grandchildren. In one son albuminuria was discovered during a life insurance examination at the age of 18. The blood urea nitrogen was within the normal range and has remained so. His serum uric acid was in the low gouty range and his urinary specific gravity was 1020, but he showed a persistent albuminuria. There wasn't a single examination of his urine that didn't show albumin.

When a patient has a positive family history, a persistent albuminuria, and a persistent hyperuricemia, one might raise the question whether or not to place him prophylactically on antigout agents. I am sure there are those who sincerely believe we do the patient a disfavor by withholding medication. I chose, instead, to continue observing this patient, since medication could be started at any time. We now have a 15-year follow-up on the son, and he hasn't, by our laboratory studies, shown any evidence of progression. Nor has he experienced an acute attack of gouty arthritis.

The question has been raised us to whether or not coronary disease has a higher incidence in patients with gout than in non-gouty males. I am of the opinion that this is not valid. If we are dealing with a group of men in the 50's and 60's, we expect to find an occasional subject develop coronary disease and die of myocardial infarction. One bit of evidence from the Framingham Study appears to show a higher incidence of coronary sclerosis and generalized vascular disease in association with hyperuricemia.

Most important in treatment is the prevention of the recurrences of acute attacks. If we have a satisfactory prophylactic regimen for our patients, irrespective of mild, moderate, or severe gout, we should worry little or not at all about the return of acute attacks, providing the patient remains on daily medication.

Because we are dealing with a dual problem, articular distress and an essentially unrelated problem of uric acid metabolism, we are fortunate in having several agents that are of value both in the uric acid phase and in the treatment of

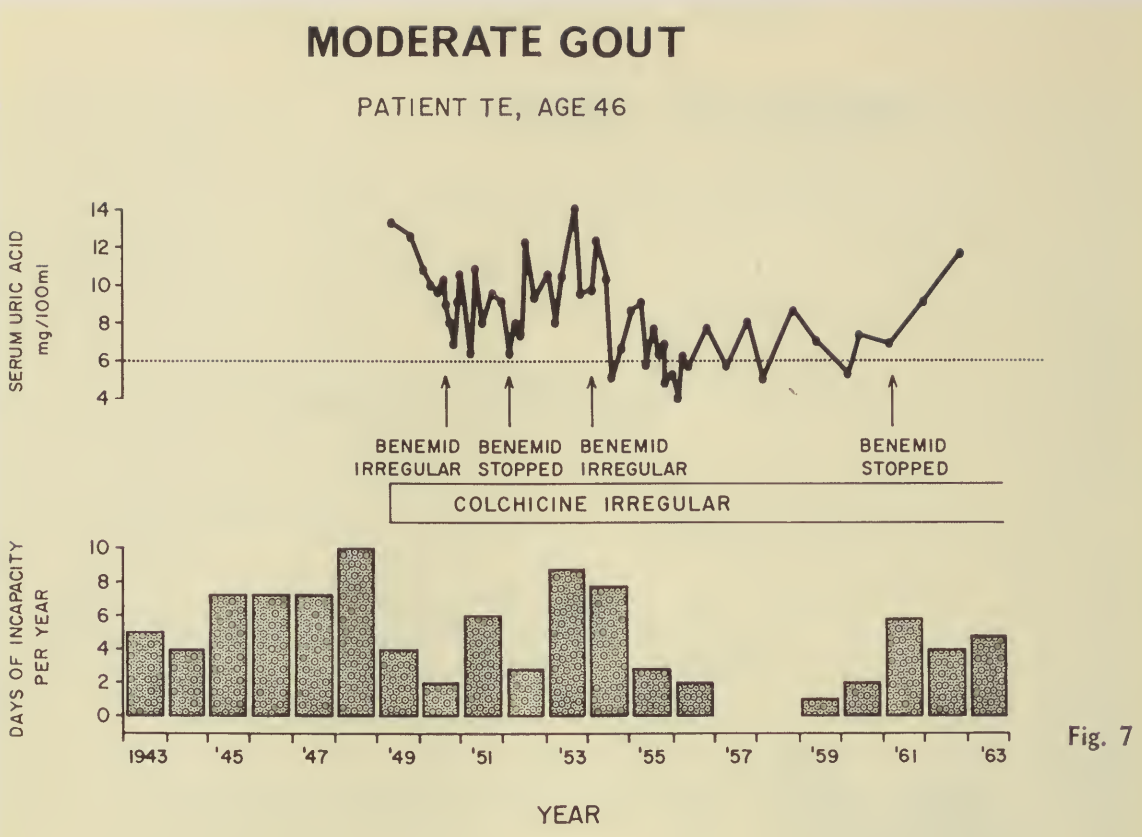

MODERATE GOUT
PATIENT TE, AGE 46
SERUM URIC ACID mg/100ml
14
12
10
8
6
4
BENEMID IRREGULAR
BENEMID STOPPED
BENEMID IRREGULAR
BENEMID STOPPED
COLCHICINE IRREGULAR
DAYS OF INCAPACITY PER YEAR
10
8
6
4
2
0
1943
'45
'47
'49
'51
'53
'55
'57
'59
'61
'63
YEAR

Fig. 7

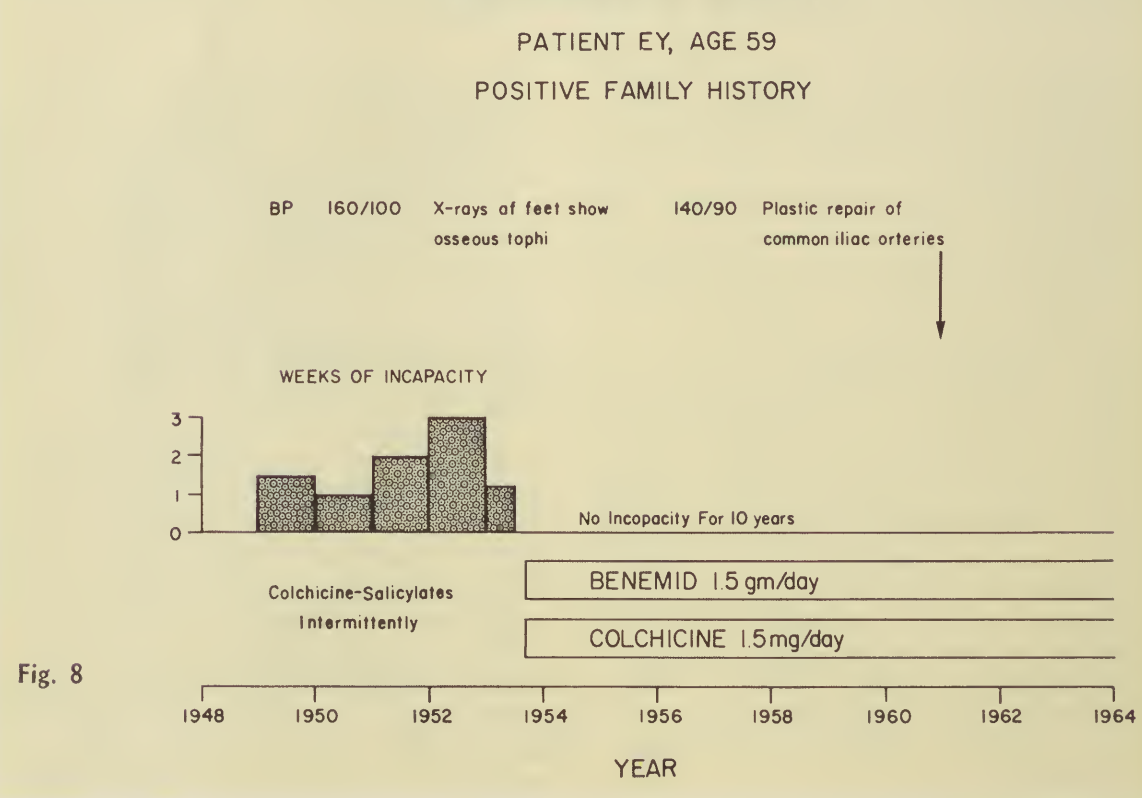

MODERATE GOUT
PATIENT EY, AGE 59
POSITIVE FAMILY HISTORY
BP 160/100
X-rays of feet show osseous tophi
140/90
Plastic repair of common iliac orteries
WEEKS OF INCAPACITY
3
2
1
0
No Incopacity For 10 years
Colchicine-Salicylates Intermittently
BENEMID 1.5 gm/day
COLCHICINE 1.5mg/day
1948
1950
1952
1954
1956
1958
1960
1962
1964
YEAR

Fig. 8

the acute articular attacks. The adequate prophylactic regimen includes drugs to prevent the recurrence of articular distress and agents that are aimed to lower the uric acid content of the blood.

Figure 6 shows observations on a patient who was followed for 25 years in our clinic. While he was in the service, in 1941, no diagnosis was made of his acute articular distress. In 1947, his serum uric acid was approximately 9mg/100ml. At that time he was placed on two tablets of colchicine a day. He had enjoyed a satisfactory response to colchicine without recurrences, but during this period essentially no change in his uric acid concentration was registered until probenecid, 2 Gm daily, was added. Throughout most of the subsequent period, his uric acid has been less than 6mg/100ml, a satisfactory response to the uricosuric agent. There have been a few mild attacks of arthritis but no time lost from work over a 16 year period.

In contrast, fig. 7 illustrates experimental data of an irascible patient insofar as his gout was concerned. He suffered from moderate gout with minimal changes shown on x-ray of the feet. His recorded past history began in 1943; he was seen first by us in 1949. He reported one or two weeks of incapacity during this interval. When he was seen first he was placed on colchicine, but he was not cooperative and took his medicine irregularly. His prescription for colchicine and probenecid was not refilled as often as recommended. This was matched by a fair response only to prevention of recurrences.

He was placed on probenecid in 1951 and experienced a good response as far as the serum uric acid was concerned when taking the drug, which was only irregularly. The serum uric acid fluctuated considerably, while the drugs were stopped on two occasions. There was little or no clinical benefit during the 10-year period, as measured by days of incapacity, attributable directly to his irregular medication. If a patient is placed on prophylactic medication, he must be as conscientious as if he were diabetic with an oral or parenteral preparation.

Figure 8 shows data from a patient with moderate gout with a positive family history. We first saw him in 1954 and have his record from his family doctor since 1948. At this time he had roentgenographic evidence of tophi, and the blood pressure was at the upper limit of normal. He was placed on probenecid and colchicine with essentially no incapacity for 10 years. He underwent a plastic repair of his iliac arteries in 1961 and did very well, suffering no postoperative gout. He is living a normal life, doing what he wants to do in every respect, but he is careful as far as daily ingestion of his colchicine and probenecid.

Colchicine remains our most helpful drug in the treatment of the acute articular distress for most patients. If a patient is seen within the first 24 or 36 hours after the onset of symptoms, and 1 mg or two tablets are taken every two hours —the equivalent of one tablet each hour—until the onset of gastrointestinal distress, an excellent response may be anticipated. This usually requires 10 or 12 tablets, sometimes 14 or 16.

Another anti-gout agent available during the last decade may be prescribed in doses of 400 to 800 mgm for one or two days. One need not worry about complications or side effects at this dose level for this period of time. This drug has the additional advantage of not being associated with gastrointestinal disturbance as colchicine is. However, one of the principle advantages of colchicine is that if a patient is on daily medication he has a head start on aborting an acute attack.

More recently, a new drug has become available. Allopurinol has been used extensively in England and experimentally in this country. The drug is a xanthine oxidase inhibitor which works at a totally different position in the uric acid cycle. While probenecid increases the excretion of uric acid by inhibiting the reabsorption of a portion of the substance from glomerular filtrate, allopurinol strikes at a more susceptible place in the degradation pathway of the purines to uric acid. The experience to date is most encouraging. The drug must be taken regularly. Reports of allopurinol toxicity are minimal.

Some physicians are uncertain as to what diet to recommend in the intercritical period. I believe it much more important to give attention to the caloric intake if the patient has a tendency to obesity than to pay meticulous attention to the purine content of foods. A few substances high in purines, such as liver, kidneys, sweetbreads, which usually are not regular components of an average American diet, should be avoided. A good portion of red meat is allowable each day. I never issue printed diets to the patient. If he

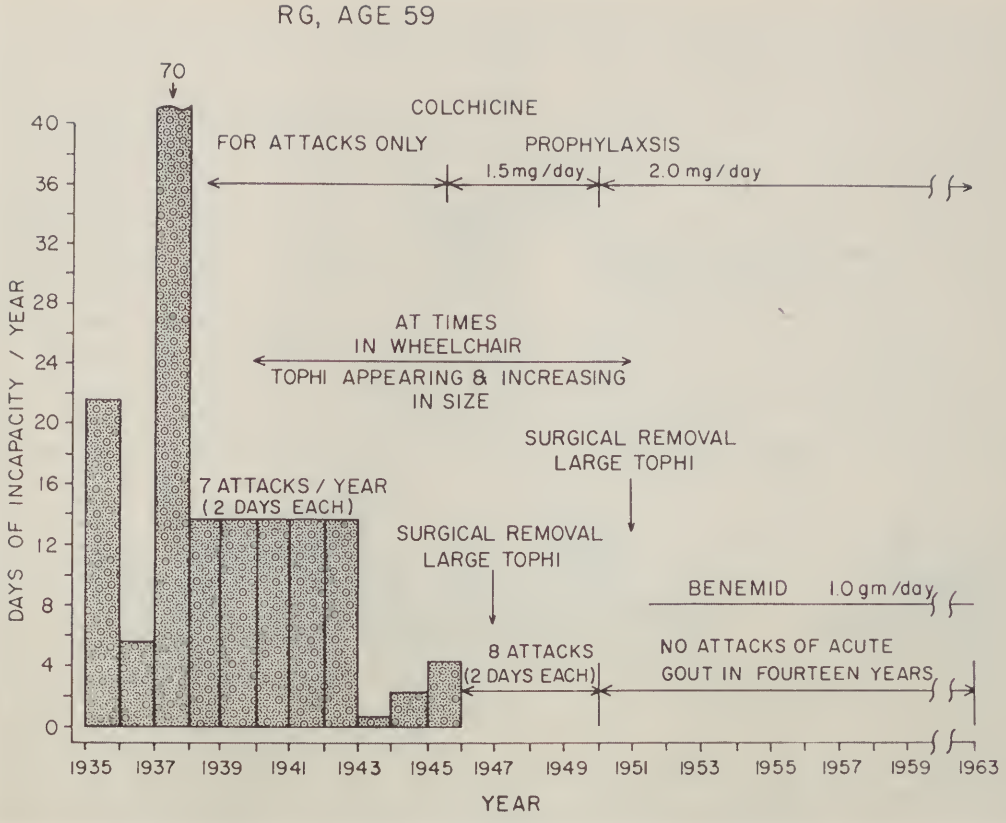


Fig. 9

takes his drugs regularly, he may eat what he wants except for a restriction of calories.

Irrespective of the uricosuric agent, the patient must have a high fluid intake. Since the solubility of uric acid in urine is not great, unless we provide added fluid for excretion, we may increase the tendency to formation of uric acid stones. On the other hand, a patient with a liberal fluid intake need not anticipate an increased incidence of renal stones. This conclusion is based upon a 10-year follow-up since the introduction of probenecid, in comparison with a previous 10-year period. I recommend no restriction upon the intake of alcohol. The harmful effects of alcoholic beverages have been noted in the literature for generations without control observations. There is little evidence that alcohol in moderation in any way deters the satisfactory clinical progress of the patient with gout on adequate and regular medication.

Figure 9 shows selected observations during a 30-year clinical history. One of the advantages of dealing with chronic disease is the opportunity to follow patients for long periods of time. We were provided a good record from this patient's family doctor before 1945, during which time he was getting into more and more trouble. When seen first, he was placed on colchicine for acute attacks only. Then he realized that the premonitory symptoms should be heeded with early administration of colchicine rather than waiting 24 or 36 hours to see whether a full blown attack was inevitable. He reported a significant reduction in days of incapacity with this change. But tophi began to appear and increase in size, and in 1947 several tophi were removed from his hands, knees, and feet. At that time he was placed on prophylactic colchicine, three tablets a day, and did very well. In 1952, probenecid, two tables a day, was added.

Observations on mortality include a 20-year follow-up of 47 patients. The total patient years exceeded 1,000. The expected number of deaths was approximately 26. Our observed mortality was approximately 27. No significant difference in the mortality from patients with gout from the average non-gouty white male in the United States was observed.

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STANDARDIZED SENNA CONCENTRATE IN POSTPARTUM BOWEL REHABILITATION

A retrospective study of three years' experience with routine oral administration of a neuroperistaltic stimulant, standardized senna concentrate, in treating postpartum constipation suggests that the regimen employed is a highly satisfactory replacement for routine enema. Satisfactory evacuation with normal stools was achieved by the third postpartum day in 95% women studied. Most achieved such evacuation by the second postpartum day.

Enemas were required to obtain normal evacuation in 1.4%. This is an estimated saving of nearly 1,500 enemas, as compared with the usual third-day regimen.

The incidence of severe cramping was less than half of one per cent, and of all cramping, 3.7%. No other side effects were noted. There were no problems of acceptance of the medication, except in a few cases of severe cramping, some of which were probably caused by overdosage.

MICHAEL B. MONIAS, MD

Because constipation in the immediate postpartum period is the rule rather than the exception, enemas are often administered routinely on the second or third postpartum day. These can be uncomfortable and embarrassing to the patient, as well as relatively expensive and time-consuming —not an inconsiderable problem in the light of current concern over hospital costs and shortages of personnel.

Until mid-1960, it was our practice to administer enemas on the third postpartum day to patients who had not had an evacuation by that day. In an effort to eliminate this procedure, we substituted for it the routine oral administration of tablets of standardized senna concentrate (Senokot), a purified and standardized preparation derived from the deseeded senna pod. As a neuroperistaltic stimulant, this medication appeared to be specifically indicated for combatting the constipation attendant upon changes in the smooth muscle of the intestinal tract resulting from pregnancy and delivery,[1] enforced bed rest, reduced fluid and food intake, and surgical anesthesia and drugs associated with delivery.

From the Anne Arundel Hospital, Annapolis, Md.

This is a report of three years' experience with this regimen for treating postpartum constipation.

Method and Materials

Over the three-year period, standardized senna concentrate tablets were administered routinely to 1,924 postpartum patients. Of these, 521 were primiparas.

Doses of two tablets each were administered in the morning and in the evening of the first two postpartum days. Medication was discontinued when a patient had a normal evacuation. The maximum total dose was eight tablets. If no evacuation occurred by the evening of the third day, an enema was given.

When satisfactory evacuation took place initially after administration of the preparation on the first or second postpartum day, the result was rated *excellent*. When it took place initially on the third postpartum day, it was rated *good*. When there was unsatisfactory or no evacuation by the end of the third postpartum day, or when medication had to be discontinued before the course of therapy was completed, the rating was *poor*.

Results

Of the 1,924 patients treated with this regimen over a three-year period, 1,824 (95%) had satisfactory evacuation on or before the third postpartum day; 1,730 of these had satisfactory evacuations on or before the end of the second postpartum day.

There was no significant difference in results between primiparas and multiparas. Since most patients evacuated satisfactorily during the second day, after routine ingestion of the third dose, the average number of tablets per patient was six.

Of the 100 patients in whom the medication was adjudged poor, 73 had inadequate evacuation, and 27 required enemas because there was no evacuation. The enema rate over the three-year period was 1.4%.

Cramping was reported by 72 patients. It was severe in 11 cases, moderate in six, and mild in 55. This may have been due to overdosage in some cases. No other side effects were noted, and the medication was readily accepted except in the few cases of severe cramping. Most patients reported gentle evacuation with well-formed stools.

Comment

Several recent studies suggest that 75-85% of parturients, if untreated, do not have bowel evacuation by the end of the third postpartum day.[2-4] This accords with our impression based on experience before institution of the described regimen. Hence, about 1,500 enemas would have been administered, under prior practice, to the patients in this three-year series. Since 27 were actually administered, the saving in patient comfort and hospital expense was substantial.

Administration of the test tablets was initiated in the morning of the first postpartum day, since we feared that a longer waiting period might increase the amount of medication required for satisfactory evacuation and delay restoration of regular bowel function. With satisfactory evacuations occurring in 95% of all patients by the third postpartum day and the incidence of severe cramping in only little more than half of one per cent, we consider the oral regimen with standardized senna concentrate a highly satisfactory replacement for the third-day enema.

121 Cathedral Street
Annapolis, Md

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RESOLUTIONS

Important Notice for Component Medical Societies and Individual Members of Medical and Chirurgical Faculty

All resolutions or recommendations for presentation to the House of Delegates must be in the Faculty Office by Tuesday, March 1, 1966, which is eight (8) weeks prior to the Annual Meeting. This is referred to in the following quote from the Faculty Bylaws:

. . . A Reference Committee of five members of the House of Delegates to which all Resolutions involving questions of Faculty policy, except those proposed by the Council or committees of the Faculty, shall be referred at least eight weeks prior to any regular session . . . of the House of Delegates. All such resolutions shall be reported to the House of Delegates with the committee's recommendations, provided that, with the sponsor's approval, the committee may revise any resolution.

The meeting of the Reference Committee is open to all members of the Faculty in good standing, who may attend and express their opinions. Notice of the date and place of the Committee meeting will be sent to all members.

RESOLUTIONS for April 1966, House of Delegates must be in the Faculty Office by TUESDAY, MARCH 1, 1966

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Contraindications: It is suggested that Provest not be used in patients with a history of genital or breast malignancy, thromboembolic disease, or hepatocellular or renal disease unless the advantages of this type of therapy outweigh the possible disadvantages. Precautions: Alert patients to possibility of amenorrheic cycle and instruct them to resume Provest tablets on the 7th day following their previous 20-day course, even though the menstrual flow failed to appear. Use drug with caution in patients with cardiac disease, epilepsy, migraine, or asthma. Since fibroids may increase in size with Provest use, watch patients with fibroids. Endometria submitted from patients taking Provest should be suitably labeled for the pathologist making the examination. Use drug carefully in patients with endocrine or metabolic diseases, such as diabetes, since it has not been evaluated in patients with all types of such disorders. Side Effects: Intermenstrual bleeding or spotting may occur, especially in the first two to three cycles of therapy and usually between the 15th to 20th days of medication. Suggested management: (1) spotting—no change in therapy; (2) menses-like bleeding (at mid-cycle or after)—increase to two tablets daily until bleeding recedes or consider this bleeding as a menstrual period, discontinue medication to allow withdrawal bleeding to be completed, and reinstitute therapy on the 5th day of the new cycle. Organic disease should be ruled out if persistent irregular intermenstrual bleeding occurs. Most side effects are those also found in early pregnancy: nausea and/or vomiting, breast tenderness, headache, fatigue, increased or decreased libido, or, very rarely, hair loss. These side effects are minimal and tend to disappear with continued treatment. Dosage and Administration: Administer cyclically one tablet daily from day 5 through day 24 of the menstrual cycle. Available: Provest Daypak of 20 tablets, and bottles of 500 tablets.

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CANDICIDIN

A NEW VAGINAL MONILICIDE

A Test Series

Vaginal infections have long been a thorn in the side of gynecologists. Of special prominence, both as to frequency of occurrence and difficulty of treatment, has been the trichomonas infestation. In recent years, however, moniliasis or candidiasis appears to be supplanting it as the primary vaginal invader. This apparently has been brought about, in part, by 1) the more general use of antibiotics and 2) the increased virulence or resistance, or both, of the causative yeast-like organisms. Vaginal moniliasis has long been a special problem in diabetics[1] and in pregnant patients, presumably because of a greater tendency toward monilial growth in the glucose-glycogen rich vaginal epithelium and secretions in these two conditions.

Reports as early as 1840, noting vaginal yeasts, indicated that these infections have been treated for decades with numerous agents and with varying results. Efforts to eradicate this condition have been less than uniformly successful, and a need for more efficacious therapy has persisted. While Pickhardt and Breen[2] reported that 99% of cases with vaginal moniliasis were cured with gentian violet, many required up to four two-week courses of treatment. Lang and co-workers[3] obtained a 52% cure rate in pregnant patients treated with nystatin. This was increased to 76% after a second course of treatment. In nonpregnant patients, the cure rate was 79% after one course and 92% after a second course. Other reported cure rates varied from 50% to 100%.

A new agent, candicidin (Candeptin), may be a solution to this problem. Isolated from a culture similar to *Streptomyces griseus,* candicidin has shown far greater *in vitro* antifungal activity than such well known drugs as nystatin and amphotericin B.[4]

PROCEDURE

The study group consisted of white private patients, gynecological and obstetrical, affected with vaginal *Candida albicans.* The age span of the subjects was 20 to 46 years, with most between 25 and 35 years. Symptoms ranged from none all the way to severe pruritis, vulvitis, vaginitis, and discharge. Duration of symptoms varied from nil (occasional asymptomatic patients in whom the infection was noted during routine office examination) to more than one year.

At the initial examination an evaluation was made of the severity and type of symptoms. A vaginal culture was then taken. The diagnosis of moniliasis in this study was limited to cases confirmed by a positive culture of vaginal secretions on either the Pagano-Levin Fungus Culture Medium or the Nickerson's Medium.

Patients were instructed to insert one vaginal tablet containing 3mg of candicidin in the morning

Fifty-one obstetrical and gynecological patients with culture-proven monilial vaginitis were treated with a new antifungal agent, candicidin. With candicidin vaginal tablets, results showed 78% initial successful treatment and 93% cure after retreatment of stubborn cases. Candicidin vaginal ointment produced 100% cure in a small series of patients. There were no untoward reactions to either medication. Both were well tolerated and accepted by the patients.

HERBERT J. FRIEDEL, MD

CLINICAL FINDINGS
Candicidin Vaginal Tablets

	No.	Cured After Single Course of Therapy	Cured After Additional Course of Therapy
Obstetrical patients	23	17 (74%)	22 (96%)
Gynecological patients	17	14 (82%)	15 (89%)
TOTAL	40	31 (78%)	37 (93%)

and evening for 14 consecutive days. Some patients received 5gm of medication in the form of a vaginal ointment containing 3mg candicidin and were instructed to insert one applicatorful of ointment morning and evening for 14 days. Those patients initially exhibiting negative cultures were excluded from the study. Those with positive cultures were rechecked for symptoms, and a repeat culture made one to five days after completion of the candicidin treatment. Those patients again showing positive cultures were given repeat treatment cycles as necessary. A follow-up culture was taken approximately four weeks after the completion of the treatment cycle. Patients were instructed to have their sex partner use a condom to prevent reinfection.

RESULTS

Sixty-four patients were observed, of whom 13 had negative initial vaginal cultures and were dropped from the study. Seven of those dropped had good relief of symptoms from the use of the medication, despite failure of proof of fungal involvement. Of the 51 patients constituting the study, 40 were given tablets and 11 were given ointment. Of the patients on tablets, 23 were obstetrical and 17 were gynecological. In the ointment series, three were obstetrical and eight were gynecological.

The table summarizes results of treatment with candicidin tablets. A cure rate of 89% or better was noted in both the obstetrical and gynecological subjects. Of the patients treated with ointment, the three obstetrical patients and five of the gynecological patients were cured after one course of treatment; the other three were cured after a second course. No irritation or sensitization occurred in the patients studied.

DISCUSSION

One treatment failure in each group (tablet and ointment study), after three cycles of medication, reported a penile irritation in her husband. The men involved were referred to a urologist for treatment, and a positive fungus culture was obtained after prostatic massage. The use of condoms was recommended to avoid conjugal reinfection, but resistance was encountered for personal and religious reasons. Somewhat more favorable results could be expected with at least temporary use of condoms.

There was general but not absolute correlation between severity of symptoms and resistance to cures. Patients in later pregnancy showed somewhat greater resistance than those in earlier stages. The results with both medications appeared comparable, with a slight superiority in the ointment. Tablets were easier to use, caused less leakage, and appeared more suited to obstetrical patients, in whom an applicator might be contraindicated.

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Amphotericin B—*Fungizone*
Candicidin—*Candeptin*
Nystatin—*Mycostatin*

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for Candida...
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Precautions: Bacterial superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue therapy for 10 days in beta-hemolytic streptococcal infections. Administer one hour before or 2 hours after meals.
Supply: Capsules, bottles of 16. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. Oral Suspension, 60-ml. bottle. Each 5 ml. contains tetracycline equivalent to 125 mg. tetracycline hydrochloride and nystatin, 125,000 units.

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TUESDAY EVENING, APRIL 26, and FRIDAY MORNING, APRIL 29

Faculty Building, 1211 Cathedral Street, Baltimore

Committee on Program and Arrangements

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APRIL 27-MAY 4, 1966—IMPORTANT DATES

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

Plan now to attend the sessions at the Alcazar on April 27 and 28

FIRST AMOS R. KOONTZ MEMORIAL LECTURES

APRIL 28, 1966, by Dr. Buxton and Dr. Ballinger, eminent representatives of the two medical schools with which Dr. Koontz was so prominently connected.



Robert W. Buxton, MD, professor of surgery and head of the department at the University of Maryland, will give a lecture honoring the memory of Amos R. Koontz, MD, an internationally known and respected member of the Medical and Chirurgical Faculty, who died this past year.

Dr. Buxton, born in Joplin, Mo., received his MD degree from Kansas University and MS degree from the University of Michigan. He interned at Strong Memorial Hospital in Rochester, N. Y., and served an assistant residency in both pathology and surgery there. He was a resident in surgery at the Genesee Hospital and the Strong Memorial Hospital, then a resident in thoracic surgery at the University of Michigan from 1941 to 1943. Between 1943 and 1955, Dr. Buxton was instructor, assistant professor, and associate professor of surgery at the University of Michigan. In September 1955 he was appointed professor of surgery at the University of Maryland. He has had more than 50 articles published in medical and surgical journals.



"Postgastrectomy Syndromes" will be the title of the Koontz Memorial Lecture given by **Walter F. Ballinger, II, MD**, associate professor of surgery at The Johns Hopkins University School of Medicine. Dr. Ballinger was born in Philadelphia, attended Cornell University and the School of Medicine at the University of Pennsylvania, where he received his MD degree.

He served an internship and residency in surgery at the Columbia Division of Bellevue Hospital and the Columbia Presbyterian Medical Center in New York between 1948 and 1956. He spent two years in the army. His investigative interests include gastrointestinal, metabolic, and hematologic problems applied to surgery.

DR. MULLAN AND DR. KAMPMEIER WILL SPEAK



John F. Mullan, BCh, BAO, professor of neurological surgery, University of Chicago, will give a lecture on the treatment of pain. Born in County Derry, Ireland, he studied medicine at Queens University, Belfast, Ireland, and graduated in 1947. He served a residency in general surgery in the Royal Victoria Hospital in Belfast, supplemented by a year's study at Middlesex and Guy's Hospitals in London. After obtaining a fellowship at the Royal College of Surgeons in England, in 1951, he turned to neurosurgery and came to the Montreal Neurological Institute in 1953, finishing his residency in neurosurgery in 1955.

He then came to the United States and became a full time staff member of the University of Chicago. He has been an assistant, associate, and full professor of neurological surgery, obtaining the latter in 1963. In 1957, Dr. Mullan was certified by the American Board of Neurological Surgeons. His special interests are the surgical treatment of pain, intracranial aneurysms, and epilepsy.



Born in Iowa, **Rudolph H. Kampmeier, MD**, received his medical degree from the State University of Iowa. He trained in internal medicine at the University of Michigan and he has been on the faculties of the Louisiana State University and Vanderbilt University for many years. He became professor of medicine emeritus at Vanderbilt in 1963 and has continued as director of the division of continuing education. Dr. Kampmeier is editor of the Tennessee Medical Journal and of the Southern Medical Journal. He is a past president of the Tennessee Medical Association and of the Southern Medical Association.

The May, 1964, issue of Medical Clinics of North America, which is a collection of papers dealing with syphilis and other venereal diseases, was dedicated to Dr. Kampmeier. An accomplished diagnostician and clinician, Dr. Kampmeier ranks among the most distinguished syphilologists. His lecture for the coming annual meeting is **"Syphilis: Then and Now."**

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During the Bermuda Cruise Convention



Dr. Cornbrooks



Dr. Mech



Dr. Rappeport

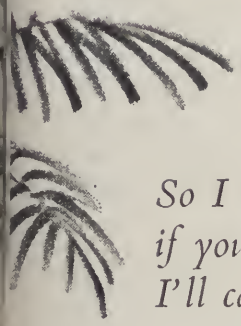
are among the lecturers

"**The Endometrial Aspiration Biopsy**" is the title of the lecture to be given by **Ernest I. Cornbrooks, Jr., MD.** Born in Newport News, Va., Dr. Cornbrooks graduated from St. Johns College, Annapolis, and received his MD degree from the University of Maryland. He was on a rotating internship at the University Hospital for two years, followed by an assistant residency and a residency in gynecology. He was a commander in the United States Navy from 1941 to 1946. He is a member of, and has held office in, numerous medical and lay organizations. He was certified by the American Board of Obstetrics and Gynecology in 1949. Dr. Cornbrooks is associate professor of gynecology at the University of Maryland School of Medicine and chief of the Oncology Clinic of the Greater Baltimore Medical Center.

Karl F. Mech, MD, will give a paper entitled "**Surgical Considerations in Gastrointestinal Bleeding.**" After receiving an MD degree from the University of Maryland School of Medicine, he served a surgical residency at St. Agnes Hospital, Baltimore. Since then he has been engaged in the private practice of surgery. Dr. Mech has taught at the University of Maryland continuously, except for four years of army service. During his army service, he had an active part in the development of the use of antibiotics, particularly penicillin, in the treatment of war wounds. His current positions are: associate professor of anatomy and assistant professor of surgery at the University of Maryland School of Medicine, chief of the department of surgery at St. Agnes Hospital, member of the Board of Medical Examiners of the State of Maryland, and treasurer of the Medical and Chirurgical Faculty. He is also a surgical consultant to the U. S. Army, serving at Fort Meade and the Veterans Administration Hospital at Fort Howard. Dr. Mech is certified by the American Board of Surgeons.

Jonas R. Rappeport, MD, president of the Maryland Psychiatric Society and assistant clinical professor of psychiatry at the University of Maryland School of Medicine, will speak on "**Sex in Marriage Counseling.**" Dr. Rappeport was born and educated in Baltimore, receiving his MD degree from the University of Maryland in 1952. He interned at Michael Reese Hospital in Chicago and took his psychiatric training at the University of Maryland Psychiatric Institute and the Sheppard and Enoch Pratt Hospital. He has held staff positions at the latter hospital and the Spring Grove State Hospital. He has been in the private practice of psychiatry since 1958 and has been court psychiatrist for Baltimore County since 1959. Dr. Rappeport is a Fellow of the American Psychiatric Association and a Diplomate in Psychiatry of the American Board of Psychiatry and Neurology.





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Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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HISTORY OF THE BALTIMORE CITY HOSPITALS

BY DOUGLAS CARROLL, M.D.



Chapter 2.—Physicians, Medical Education and Almshouses: Advances in Baltimore (1773-1822)

The zeal for study and eager desire of acquiring knowledge, that at present distinguish the students of medicine in Baltimore, have with much satisfaction been observed by some of the physicians of this place, who being desirous to aid and cherish as far in their power so laudable a spirit have entered into an association to establish a medical school here the ensuing winter, where youth who are engaged in the study of physic shall have opportunities of hearing courses of lectures . . . the advantages to be derived from a public hospital are too apparent to require illustration . . . At an early period of the ensuing winter courses of lectures . . . will commence:

(Andrew Wiesenthal's advertisement for medical students, Maryland *Journal* for March 29, 1790.)

Almshouse Physicians in the Eighteenth Century

During the early years of the Almshouse, a number of distinguished men served as visiting physicians. In 1789, Dr. Andrew Wiesenthal (1762-1798), the son of Baltimore's leading physician, returned to Baltimore. He was a sanguine and ebullient young man-about-town, an accomplished musician, who had enjoyed his three years of training at St. Bartholomew's Hospital in London. He became attending physician at the Baltimore Almshouse in 1789. This gifted physician made a major contribution to medical science when he discovered that a round worm in the trachea was the cause of syngmosis ("the gapes"), an important epizoötic disease in domestic fowl. This was the first discovery ever made of an organism's producing an infectious disease or epidemic. The posthumous report of his findings appeared in the London *Medical and Physical Journal* of 1799. Together with several other physicians who had been inspired by the advanced medicine in Europe and appalled by the low state of medical practice in the United States, he founded a medical school, hoping to use the Almshouse as a source of patients to be demonstrated to the students.

In England, the medical schools had been organized around hospitals rather than around physicians in practice. This method had been tried at the Pennsylvania Hospital (opened in 1752) but had not been successful because the physicians found it more profitable to give lecture courses and receive fees directly from each student. The same thing happened in Baltimore. Since there were no licensing boards, no diploma was needed to practice medicine. Not until 1870, after many heartbreaking attempts, was the apprenticeship system finally abandoned (at Harvard and Pennsylvania). Universities took over the quality control of medical education and the awarding of diplomas. Medical teachers went onto the payroll of the medical schools.[1] Unfortunately, Weisenthal's efforts to found a medical school was not carried beyond a series of lectures on anatomy and surgery to a class of 15 students in 1789-90. At the same time, George Buchanan, an Edinburgh student and graduate of the University of Pennsylvania in 1789, lectured on diseases of women and children. The medical school closed with Weisenthal's early death.

The Almshouse was not used for patient mate-

rial until about 1812, when Drs. William Gibson and Samuel Baker, professors of surgery and materia medica at the College of Medicine of Maryland (later the University of Maryland Medical School), accepted visiting physician appointments at the Almshouse on condition that their students should have the privilege of clinical instruction there. The clinics at the Almshouse were chiefly surgical operations.[2]

During the last decade of the eighteenth century, the seeds of a Baltimore medical school were planted. In addition, the Medical and Chirurgical Society of Maryland was started by many of those interested in medical education. In 1793, Baltimore started the first continuously operating health department in the United States.[3]

Another distinguished physician associated with the Almshouse was Dr. James Smith (1771-1841). Called the Father of Vaccination in Maryland, he started the widespread practice of vaccinating against smallpox in 1801. He kept good case records. These show that his first patient was Nancy Malcum, age 7, an inmate of the Almshouse.

The founding of vaccination schools by the national government (one of the first under Dr. Smith in 1813) was one of the earliest examples of federal interest, financing, and responsibility in public health. Medical advances continually demonstrated that major communicable diseases could be prevented by control of water supply and sewage disposal, by quarantine and isolation, by mass vaccination, and by food and milk inspection.

The trustees of the Almshouse in 1818[4] reported that there was an overseer, a full time physician and seven visiting consultant physicians and surgeons, a purveyor, a druggist, and a matron. All of the physicians and surgeons were professors at the newly founded College of Medicine of Maryland. The inmates led a spartan life. All rooms were whitewashed with good quicklime and slaked with boiling water in the spring and fall. One bed was allowed for each adult. No more than two children could occupy a single bed. The bed ticks were washed and filled with clean fresh straw and the blankets washed twice a year.

Public interest in medical education continued. Although knowledge then was meager compared with today, there was a widespread demand for more physicians. Furthermore, hospitals were rapidly becoming physicians' workshops.[5] Reputations could be made in hospitals. Their superior opportunities for student teaching were recognized. At the Baltimore City and County Almshouse in 1818, students of medicine and surgery were urged to accompany visiting physicians, on payment to the trustees of $10 a year. Two medical students were boarded and lodged for two years on the payment of $150 each.

After 1805, the city needed the land on which the Almshouse stood for residential development. In 1819, 306 acres west of the city was bought for the Almshouse, and all the inmates were removed to that location in 1822.

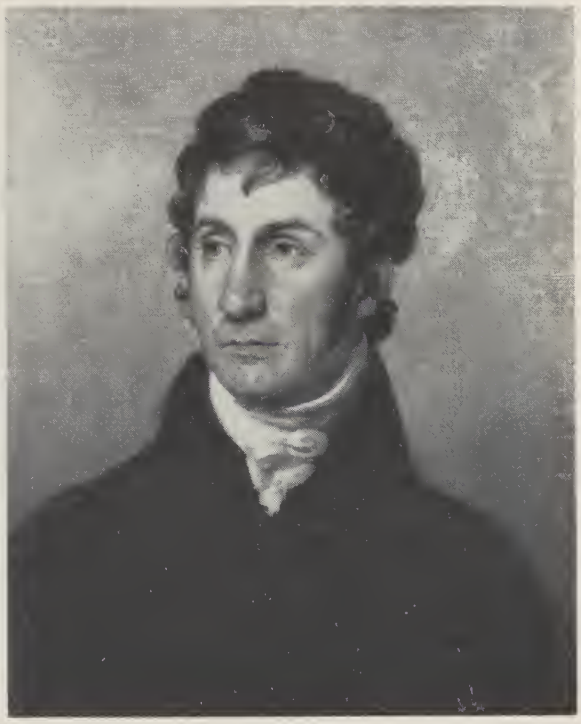


Fig 1

James Smith (1771-1841) AM, Dickinson College (1792), pupil of Dr. Benjamin Rush, University of Pennsylvania (1794), resident physician, Baltimore City and County Almshouse (1800-01), performed his first vaccination on May 1, 1801 (less than a year after Benjamin Waterhouse performed the first vaccinations in the United States) at the Almshouse. He did a great deal to publicize and establish vaccination in the United States.

(Artist, Rembrandt Peale (1778-1860), painted around 1813-15. Dangerfield Collection, The Baltimore Museum of Art)

Changing Function of the Baltimore Almshouse

During this early period, the Almshouse and Workhouse were used as a depository for the social problems of the growing city. "Rogues, vagrants, vagabonds, beggars, and other idle, dissolute, and disorderly persons" were sentenced for three months of hard work in the Workhouse. The Almshouse took care of the infirm, the orphans, the sick, the insane, the psychopaths and the "juvenile delinquents."[6] As time went on, the need to separate the various groups from the Almshouse and Workhouse became evident. The penitentiary, in 1811, took some of the criminals who did not properly belong in the Workhouse. In 1828, the state began to take some of the pauper insane at the Maryland Hospital, located at the site of the present Johns Hopkins Hospital.

Orphans have always been an especially appealing group for charitable efforts. The Baltimore Female Orphan Society, established in 1808, afforded shelter and education to destitute orphans.[7]

Thus, during the period 1773-1822, the State of Maryland began to take some responsibility for the insane and the criminals; private charity helped, particularly with children. From a welter of social problems of all types, specialized institutions arose to cope with particular problems.

American Almshouses

Compared to similar sized almshouses in London[8] during this period, the Baltimore Almshouse was less crowded and administration was less suppressive. Physicians in private practice appointed to visit at a hospital could build a reputation in the community. The Almshouse was the only institution in which sick people were cared for. The leading physicians of Baltimore were, therefore, willing to give their time for teaching and patient care. The leading physicians and professional people were eager to serve as trustees.

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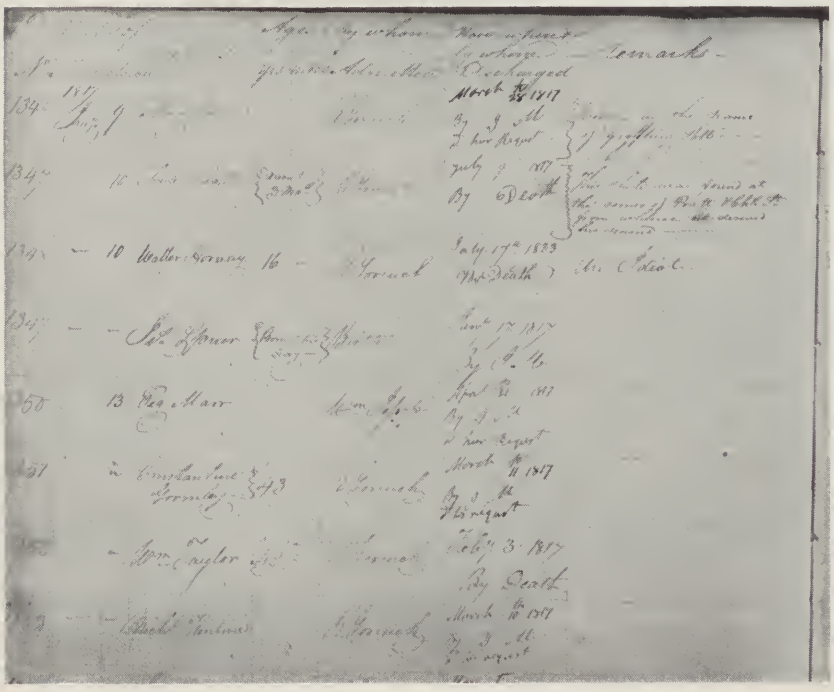


Fig 2

Page from Almshouse Admission Book for January, 1817.



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WICOMICO COUNTY

Charles Bagley, III, MD, was installed as 1966 president of the Wicomico County Medical Society, Inc., at its December meeting. The third generation of his family to serve as a medical society president, Dr. Bagley has practiced psychiatry in Salisbury since 1961. Active in many professional organizations, he has also been chief of the Department of Psychiatry at the Peninsula General Hospital for the past year.

Other new officers include **Marcus Stephanides, MD,** vice-chairman and president-elect; **Robert L. Dickey, MD,** secretary-treasurer; **Richard E. Hughes, MD,** member of the Board of Censors; **H. Douglas Cooper, MD,** and **Andrew C. Mitchell, MD,** delegates to the Medical & Chirurgical Faculty; and **Frank E. Poole, MD,** and **Robert T. Adkins, MD,** alternate delegates.

Mr. Jack Ward was the speaker for the program. He discussed the organizational structure of Jehovah's Witnesses and the background of their beliefs leading to refusal of blood transfusions. A general discussion followed on medical treatment of Jehovah's Witnesses within the framework of their faith.

Mr. David Pedwell, also a member of this faith, concluded the program by expressing willingness of Jehovah's Witnesses to cooperate with the medical profession in attempting to meet medicolegal problems involved.

All in attendance agreed that progress was made in clarifying this situation, including moral problems faced both by members of Jehovah's Witnesses and by the physicians who treat them.

Mrs. Kit Hargreaves



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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et ol.: Med. Times, 87:818, 1959.

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The Lymph Node Biopsy in Infectious Diseases

D. J. WINSLOW, MD
R. J. HARTSOCK, MD

THE PATHOLOGIST FREQUENTLY has the difficult problem of determining the cause of an infectious process from a surgically excised lymph node. The complete biopsy specimen may have been placed in fixative in the operating room, and no fresh tissue is available for culture or animal inoculation. Sections of the lymph node must be studied to determine the type of lesion and the presence or absence of microorganisms. Numerous infectious agents may be found in properly stained sections of lymph nodes, including viruses, rickettsiae, bacteria, fungi, protozoa, and helminths. Microscopic examination of many slides and the use of the oil-immersion objective may be required to define the offending organism.

There seems to be no simple, economical method for determining the cause of infectious processes in lymph nodes. The pathologist should, of course, be informed of the patient's history and the clinician's opinion as to possible diagnoses. The fresh biopsy specimen may be examined aseptically by the pathologist. A magnifying glass or dissecting microscope will aid in the study of lesions on the cut surfaces. Smears and imprints may be stained for bacteria or other microorganisms. A small part of the lymph node may also be sectioned with a freezing microtome and a hematoxylin-eosin-stained section quickly obtained. By this means the pathologist may get a clue as to which media or animals should be inoculated. Cultures and, if indicated, animal inoculations should be made with tissue removed aseptically from the inner part of the lymph node.

At least half of the lymph node should be fixed immediately in neutral, buffered formalin. Other fixatives may be used, but formalin is the best general fixative. When the specimen is trimmed before embedding, a portion should be preserved in formalin for possible later use.

Tissue reactions in lymph nodes are limited and therefore are not diagnostic of a specific etiologic agent; nevertheless they alert the pathologist to certain cause-and-effect relationships. In general, the results of cultures must be supported by the histologic features, since microorganisms not directly related to the lesions sometimes are recovered by cultural methods. The presence of a malignant lymphoma in the periphery of a necrotic lymph node may be missed if the pathologist focuses his attention on the necrosis and the bacteriologist's report. In cultures taken from a lymph node, the possibility of a contaminant must always be considered. Negative cultures, on the other hand, may be due to fastidious or nonviable microorganisms, which nevertheless may be demonstrated by appropriate histologic technics.

From the Armed Forces Institute of Pathology and the Veterans Administration Central Laboratory for Anatomic Pathology and Research, AFIP, Washington, D. C. Dr. Winslow is chief, Infectious Diseases Branch, and Dr. Hartsock is chief, Hematologic Pathology Branch.

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By careful histologic study and the application of special stains, it is possible to make an etiologic diagnosis in many infected lymph nodes. At the Armed Forces Institute of Pathology we have found the following stains of value in screening sections for a causative agent[1]:

Hematoxylin-eosin (H&E)

Virus inclusion bodies
Many bacteria
Viable fungi
Protozoa
Higher parasites

Giemsa (Giemsa)

Ricksettsiae
Most bacteria
Viable fungi
Protozoa
Higher parasites

Warthin-Starry (W-S)

Bacteria, including Donovan bodies, spirochetes, and Klebsiellae

Acid-fast stains

Ziehl-Neelsen for *Mycobacterium tuberculosis* (Z-N)
Fite-Faraco for *M leprae* (F-F)
Modified Fite-Faraco for Nocardia (F-F Mod.)[2]

Special stains for fungi

Gomori's methenamine-silver nitrate technic (GMS)[3]
Gridley's stain for fungi
Periodic acid-Schiff reaction (PAS)
Mayer's mucicarmine (Muci)
Mowry Modification of the Hale (Muller) colloidal iron stain for acid mucopolysaccharides (AMP)[4]

Special stains for bacteria

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For routine screening, the following stains are usually adequate: H&E, Giemsa, F-F, and GMS. These stains will demonstrate most agents that can be visualized by light microscopy in viral, rickettsial, bacterial, mycotic, and parasitic diseases. A W-S stain should be added whenever spirochetal infection, granuloma inguinale, or scleroma is a possibility.

If microorganisms are found by one or more of the screening stains it then may be necessary to apply one of the other differential stains listed above. For example, the yeastlike cells seen in a caseating granuloma stained with the GMS technic can be further evaluated by applying Muci and AMP stains. If the cell wall or capsule is stained positively by these stains and blastomycosis can be ruled out by other features, the yeast cells can be diagnosed as *Cryptococcus neoformans. Blastomyces dermatitidis* and *Paracoccidioides brasiliensis* must be considered when the walls of the yeast cells are stained only slightly by Muci and are positively stained by AMP. Other morphologic features will usually aid in the differentiation. If the walls of the yeast cells do not react positively to Muci and AMP stains, a diagnosis of *Histoplasma capsulatum* can usually be made on the basis of morphologic and tinctorial criteria. In occasional cases, fluorescent antibody reactions are necessary and helpful in differentiating between *Histoplasma, Cryptococcus,* and *Blastomyces.* At the AFIP it has been possible to make a diagnosis of a specific infectious disease in numerous lymph nodes by microscopic examination of histologic sections and the use of special stains. The following cases will illustrate:

CASE 1

The patient was a 10-year-old white Brazilian boy with progressive enlargement of lymph nodes, beginning with the lymph nodes of the neck. There was a history of progressive wasting, cough, and anorexia of one year's duration. Physical examination revealed generalized lymphadenopathy, enlargement of liver and spleen, and an ulcerated lesion of the epiglottis. An x-ray film of the chest showed enlargement of mediastinal lymph nodes, but no pulmonary

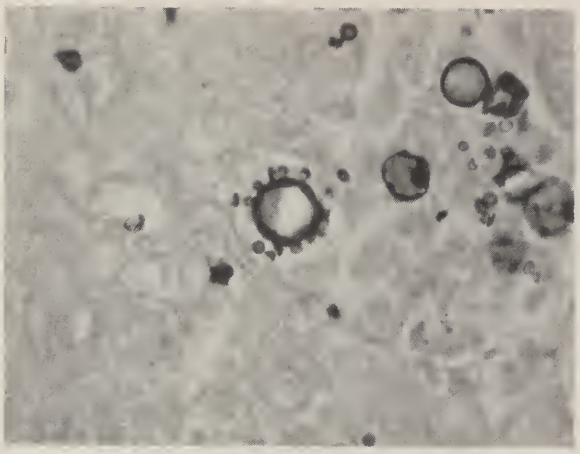


Fig 1

Case 1. Yeast cells of Paracoccidioides brasiliensis **in lymph node. Gomori methenamine-silver stain. X 1080. (AFIP Neg. 65-12065)**

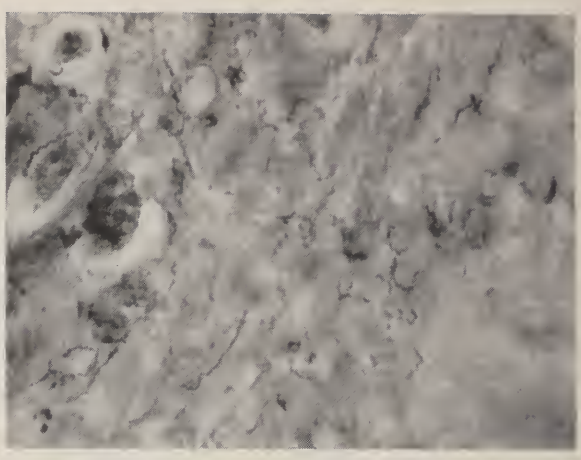


Fig 2

Case 2. Treponema pallidum **in section of lymph node. Warthin-Starry stain. X 1800. (AFIP Neg. 65-12066)**

lesions were seen. A cervical lymph node was excised and submitted for examination.

Histologic examination of H&E sections of the lymph node revealed massive necrosis, in which it was practically impossible to identify an etiologic agent. Since, however, there were structures present that looked as if they might be large yeast cells, a GMS stain was applied. This revealed numerous yeast cells, many of which demonstrated multiple peripheral budding characteristics of *Paracoccidioides brasiliensis* (fig 1).

Diagnosis: South American blastomycosis.

CASE 2

The patient was a 25-year-old white man who had a painful mass in the left inguinal region for three weeks. At surgery he was found to have multiple enlarged femoral lymph nodes overlying the inguinal ligament. There was no generalized lymphadenopathy. There was a small crusted sore on the under side of the penis, which the patient stated was due to trauma.

Histologic examination revealed a severe subacute lymphadenitis and perilymphadenitis with focal areas of severe vasculitis. In view of the history and the histologic picture, W-S preparations were made, and microscopic examination revealed numerous spirochetes with the typical morphologic features of *Treponema pallidium* (fig 2).

Diagnosis: Syphilis.

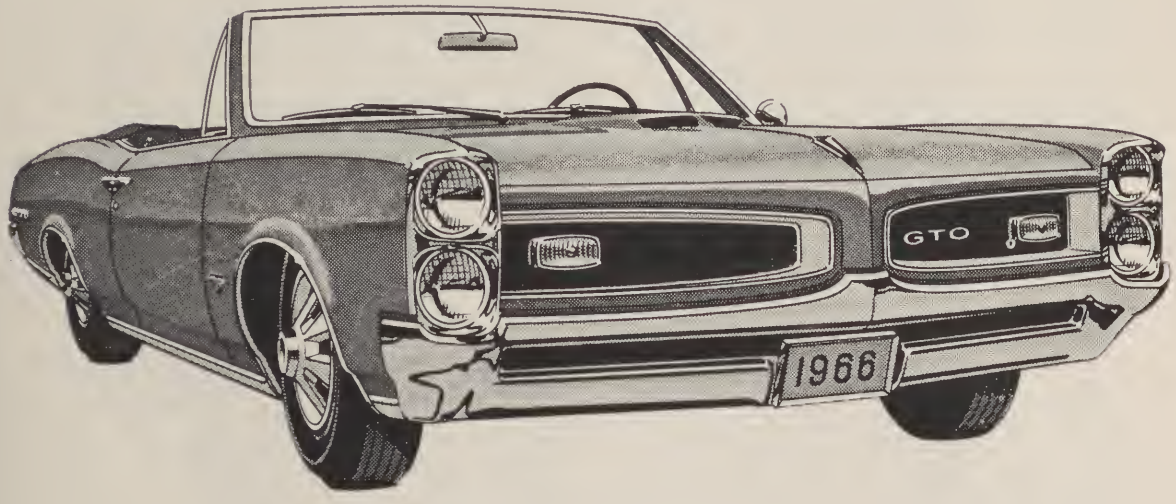
The lymph node biopsy is an important procedure in many infectious diseases. Often it offers the first or only means to a conclusive diagnosis. The excised lymph node can be studied by different methods, including those used in virology, bacteriology, and mycology. Histologic methods allow visualization of the disease in its biologic setting. Frequently the etiologic agent can be seen within the tissues and correlated with the lesions, the clinical history, and the microbiologic investigations. As a result, the clinician is able to begin specific treatment promptly.

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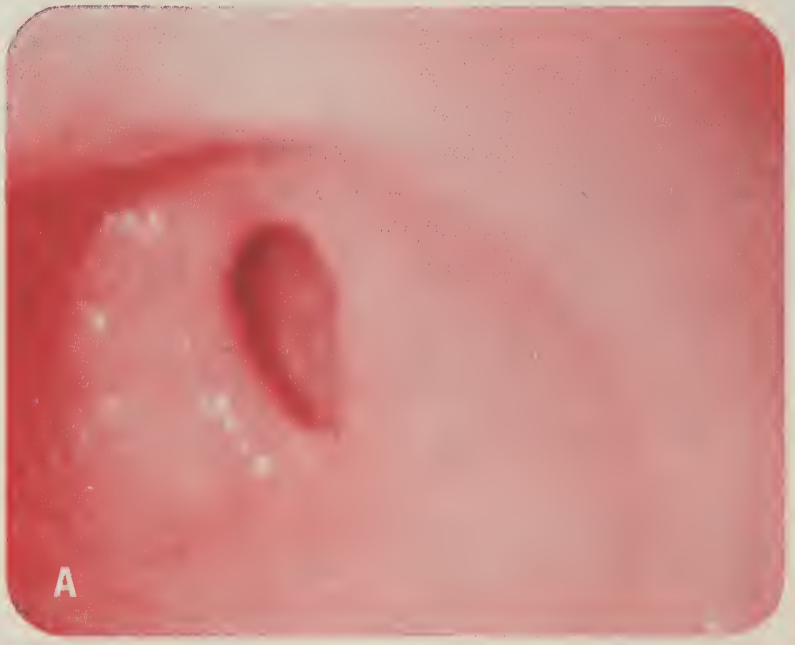


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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Medical Care in a Baltimore Nursing Home

DOUGLAS G. CARROLL, MD

The Medicare bill requires that all patients being admitted to nursing homes be given a three-day diagnostic investigation in a hospital. The question arises whether adequate standards of medical care are maintained in the nursing homes of Baltimore. A study made in 1961 and 1962 of the inmates of a Baltimore nursing home suggests that present standards and practice are inadequate.

* * * * *

On July 14, 1961, the Camphor Nursing Home in Baltimore City was closed suddenly by the Maryland State Health Department because of overcrowding. Twenty-four inmates of the home were transferred to the Baltimore City Hospitals for care.

A study of these patients has revealed that their medical care and rehabilitation needs had not been met in the nursing home. Although evidence shows that little effort was made at this nursing home to supply adequate medical care and rehabilitation facilities, it is important to note that the nursing home was closed not because of inadequacies in these areas but because of overcrowding. It is probable, therefore, that the inadequacies found in this home exist to some extent in other nursing homes.

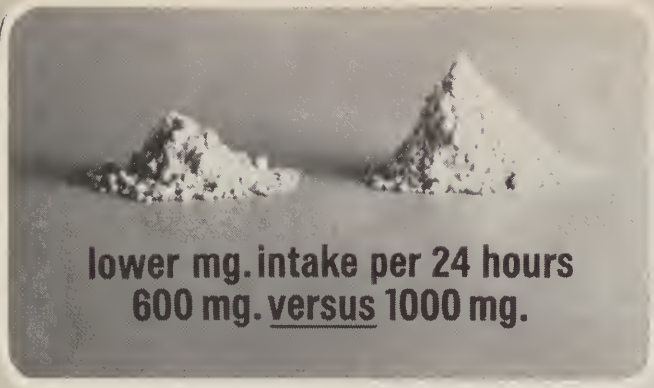
A. Age, Sex, Color, Marital Status, Living Relative, and Financial Support

The average age was 73.3 years (two of unknown ages), with a range from 51 to 96. Twelve

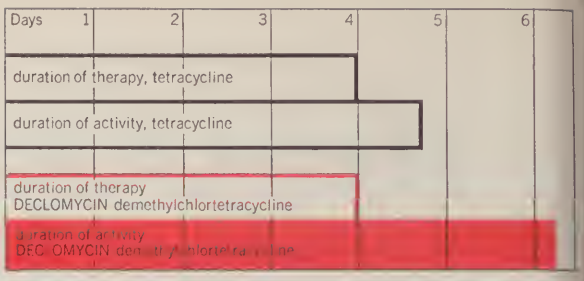
Table 1
Diagnoses in Order of Importance in Causing Disability

	1*	2**	3***	4	5
Chronic brain syndrome	9				
Arteriosclerotic heart disease	7	5	1	1	
Cerebrovascular insufficiency	2	4	1		
Amputee	2	1			
Hypertensive cardiovascular disease	1	1	3		
Epilepsy	1		1		
Neoplasm	1	2	1		
Pulmonary tuberculosis healed	1		1		
Diabetes mellitus		2	2	1	
Hernia, inguinal		2		1	
Renal disease		2	1		1
Positive serologic test for syphilis		2		2	2
Partially blind		1			
Unexplained anemia		2			
Unexplained thrombocytopenia				2	
Depression					1
Benign prostatic hypertrophy with obstruction					2

*Principal disability or disease for which patient was in nursing home.
**Secondary diagnosis.
***Tertiary diagnosis.

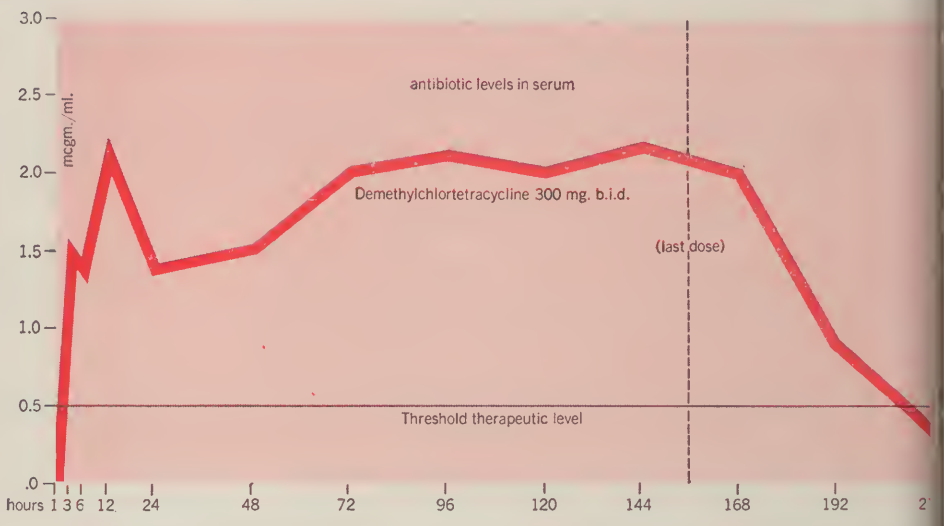


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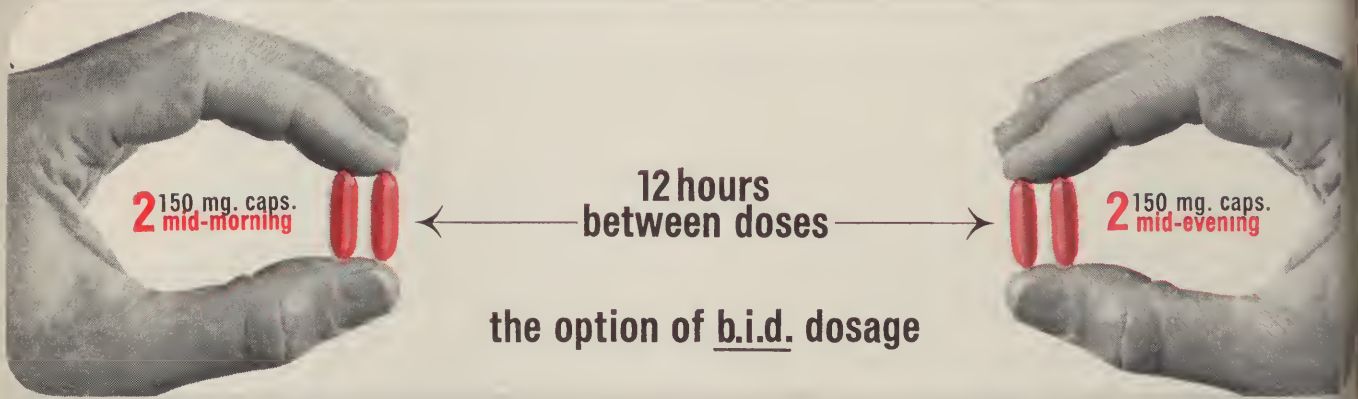


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Table 2
Unsuspected Diseases Discovered

Benign neoplasms	5	Prostatic nodule (1), Breast nodules (3), Endocervical polyp (1)
Malignant neoplasms	4	Meningioma, parotid, stomach, hepatoma
Thrombocytopenia, cause undetermined	2	
Anemia, cause undetermined	2	
Positive serologic test for syphilis	6	
Positive spinal fluid serologic test for syphilis	1	

were men; 18 were Negro. None had a living spouse. At least nine had living children.

B. Diagnosis

Most of the patients had more than one potentially fatal disease. Table 1 lists the diagnoses found after complete investigation in the hospital. Those apparently causing major disabilities are listed first, but all significant diagnoses are listed to show what diseases existed in these patients. It is obvious that arteriosclerosis of the vessels of the brain, heart, and extremities accounted for the major difficulties.

C. Undetected Diseases Present

Table 2 shows that nine neoplasms were discovered, of which four were malignant. A meningioma was suspected but could not be diagnosed by an elaborate neurosurgical investigation; the patient died. One patient refused biopsy of a breast tumor. Two patients had unexplained thrombocytopenia and two had anemia, the causes of which remained unexplained. Serologic test for syphilis was positive in six patients. Four gave no history of treatment. Since *no medical records were available on these patients,* it was assumed that they had not been treated. One patient had a positive spinal fluid serologic test for syphilis.

D. Conditions Requiring Treatment

Table 3 shows measures carried out in the hospital which probably would not have been done in the nursing home. Two patients were treated for heart failure with improvement in their independence. One patient required regulation of his diabetes mellitus. Seven biopsies were performed, revealing four benign and three malignant neoplasms. Transurethral prostatic resections were performed in three patients. Orchidectomy was performed in one patient with metastatic prostatic cancer, in whom the diagnosis had been made but no treatment instituted. Two patients were bilateral amputees. One died of parotid carcinoma; the other was fitted with a below-knee prosthesis and was able to ambulate. The four patients with positive serologic tests for syphilis and an absent history of treatment were treated. One patient had bilateral inguinal hernias successfully repaired. Cystolithotomy and urethral dilation were required in one patient.

E. Degree of Independence in Activities of Daily Living

Fourteen patients were completely independent in activities of daily living (ADL score 100); that is, they could take care of their toilet needs, their feeding, washing, personal toilet, and dressing and were independent in walking and

Table 3
Procedures Thought Necessary for Adequate Diagnosis and Treatment

Treatment of heart failure	2	
Regulation of diabetes mellitus	1	
Biopsy of suspected neoplasm	7	Prostatic (TUR), breast (2), endocervical polyp, liver, 2 lymph nodes
Transurethral resection	3	
Orchidectomy	1	
Lower limb prosthesis	1	
Treatment for syphilis	4	
Bilateral herniorrhaphy	1	
Cystolithotomy	1	
Dilatation of urethral stricture	1	
Rehabilitation	2	

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climbing stairs. Two were independent in all activities except stair climbing (ADL scores 86-95). Six were semi-independent (ADL scores 46-85) and required no special nursing services. Only two required extensive nursing care (ADL scores 1-10 and 11-25). Both of these patients died within six months of admission. The causes of death in the six patients who died were as follows:

1. Mucoepidermoid carcinoma of the parotid with metastases
2. Meningioma
3. Carcinoma of the prostate with metastases
4. Carcinoma of the stomach with metastases
5. Arteriosclerotic heart disease with enlarged heart, atrial fibrillation, and heart failure
6. Arteriosclerotic heart disease with enlarged heart, right bundle branch block, heart failure, cerebrovascular infarction with hemiplegia, diabetes mellitus with diabetic glomerulosclerosis and pyelonephritis.

Only six patients had no medical, surgical, psychiatric, rehabilitation, or nursing needs. All patients had inadequate financial, familial, and domiciliary resources.

Summary

This study demonstrates some of the medical problems arising in a nursing home. A number of unsuspected neoplasms were detected. The fact that some of these were benign is a matter of chance. Several others were malignant and possibly were curable had they been detected earlier.

Several patients were improved by better control of heart failure, diabetes mellitus, and prostatic hypertrophy. Two patients benefited by physical therapy.

This nursing home kept no medical records on any of its clients.

Adequate medical care for such patients requires an initial comprehensive medical, surgical, social, and rehabilitation investigation at the time of admission, facilities for follow-up and periodic health surveys, and continuous medical supervision and mobilization of all community resources to meet individual and group needs.

MARYLAND RADIOLOGICAL SOCIETY
ORGANIZED 1953
President—James A. Lyon, Jr., MD
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Is Cancer Curable by Radiation Therapy?

MORRIS J. WIZENBERG, MD
Assistant Professor of Radiology, Division of Radiation Therapy, University Hospital

Can patients with cancer be cured by radiation therapy, or are they merely being offered palliation or temporary arrest of the disease which will eventually cause their death? I am afraid that all too many patients and physicians share the latter view, for while many know the value of radiation therapy in palliation, few are aware of its curative role.

Cancer is not cured by the simple eradication of every tumor cell from the body. A patient who dies as a result of treatment, even though subsequent autopsy shows no evidence of residual neoplasm, is no less dead of cancer than one who dies with active tumor. Conversely, a patient who dies of some unrelated disease many years after apparently successful treatment of cancer has, for all purposes, been cured even if, in an exceptional case, autopsy reveals a focus of tumor cells in a fibrotic scar at the site of former activity. In the case of most cancers, death occurs in one or two years if no treatment is given, while the incidence of recurrence is small in those patients who survive for at least five years with no evidence of residual or recurrent neoplasms. Indeed with many tumors, such as Wilms tumor or testicular carcinomas, recurrences are rare after two to three years. Five-year tumor-free survival is, therefore, a quite sensitive indicator of cure, except for certain tumors such as breast or prostatic cancer.

Let us then look at some of the available data to see whether patients are cured. Hodgkins disease seems afflicted with a name which often paralyzes both patient and physician with fear and depression; yet Easson has shown that patients with localized disease may expect 15-year survival of 40%, and the mortaliy curve thereafter parallels that of a comparable normal population group. Even in the case of generalized Hodgkins disease, 15-year survivals as high as 11% have been reported. Seminoma can be treated to yield five-year "cure" in about 90% of cases, and the rarity of recurrence after the second year justifies the belief that most of these patients are indeed cured. Teratocarcinoma of the testis, when metastases are clinically evident, almost invariably leads to death within one year. When it is noted that about 50% of patients with teratocarcinoma of the testis have unsuspected retroperitoneal metastasis, survival of 42% of patients treated by excision of the primary and radiation therapy to the para-aortic nodes, as reported by Smithers, is highly significant. The efficacy of radiation therapy for cancer of the cervix is so well documented as to require no further comment.

Most epithelial tumors of the head and neck are lethal in one to two years in the absence of treatment. Radiation therapy can produce five-year cures in 80% or more of patients with vocal cord tumors. Twenty-five per cent of patients with nasopharyngeal cancer may be cured by irradiation, and for anatomical reasons, this is the only possible form of treatment in such cases. I could continue to add tumor upon tumor and evidence to evidence to substantiate this trend.

In affirming that radiation therapy can cure cancer, I do not mean to imply either that other methods of therapy cannot or that radiation therapy is the ideal form of cancer therapy. We must realize that even with the best treatment available, too many patients die of uncontrolled tumor. Many of these patients are beyond help other than palliation when first seen. We have had no mirac-



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ulous breakthrough in cancer therapy; nor is there the slightest shred of evidence that a breakthrough will occur soon. Advances in the development of curative chemotherapy undoubtedly will be made slowly and probably will affect only one variety of cancer at a time.

Perhaps the near future will bring some answer which will make present therapy obsolete, but until then let us use our available therapy for greatest effect. To persist in the belief that radiation therapy can provide only palliation or temporary arrest is to refuse to face the facts and use a valuable tool. This erroneous concept of the place of radiation therapy can lead only to needless suffering and death and should be exposed as the dangerous myth which it is.

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*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

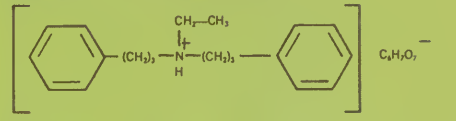
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- Neurotropic effect only 1/150 that of atropine.
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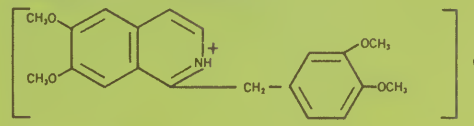


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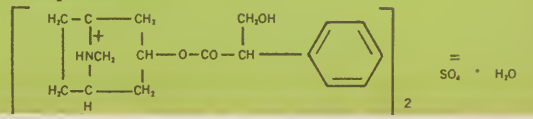
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INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets 1/2 hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Survey of Habitual Drunkenness Offenders in Baltimore

MICHAEL BASS
and
GARY GOLDSTEIN

The Department of Mental Hygiene is again including in its capital budget request for Fiscal 1967 an item for a 200-bed rehabilitation facility for habitual drunkenness offenders, to be located on the grounds of the Crownsville State Hospital.

The need for such a facility has been noted by every committee and commission assigned to study the problem of drunkenness offenders in the past 20 years, among them the following:

1946	Governors's Commission for the Study of Chronic Alcoholism
1956	Mayor's Committee on Alcoholism
1956	Baltimore Council of Social Agencies
1961-62	Maryland Commission on Alcoholism
1962-63	Medical and Chirurgical Faculty of Maryland
1963	Mayor McKeldin's Brainstorming Conference on Alcoholism Programs
1963	Advisory Council on Mental Hygiene
1963-64	Baltimore Area and Prince George's County Councils on Alcoholism
1964-65	Mayor McKeldin's Program Committee on Alcoholism
1965	State Comprehensive Mental Health Planning Unit

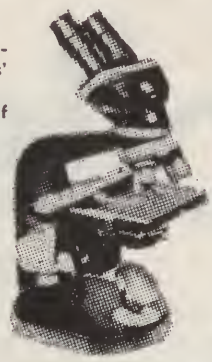
Because of the dearth of accurate data on habitual offenders, the department has been unable to submit substantial justification with its request for a rehabilitation facility. To supply the needed information, the department employed the writers (University of Maryland students of psychology and law, respectively), in June, 1965, to survey the state to determine the number of habitual drunkenness offenders in each subdivision and the disposition made of them by the several courts.

According to the Annotated Code of Maryland, Article 27, Section 123, the drunkenness offender is exclusively a local responsibility. He may be fined up to $50, jailed for up to 60 days, or both. The habitual offender, one convicted of drunkenness five times within a 12-month period, may be fined up to $100, committed to either the local jail or the Maryland House of Correction for up to six months, or both. The code thus establishes the right of the local subdivision to shift to the state responsibility for the habitual offender.

Whether or not the drunkenness offender should be a responsibility of correctional and law enforcement agencies at all, either local or state, is not so clear. Nine years ago, the American Medical Association officially recognized alcoholism as a disease, a position taken also by the World Health Organization, the American Psychiatric Association, the American Hospital Association, and many other professional bodies. In 1960, Article 2C was added to the Maryland Code. Section 1 opens with the following two sentences:

> Alcoholism is hereby recognized as an illness and a public health problem affecting the general welfare and economy of the state. Alcoholism is further recognized

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as an illness subject to treatment and recovery and the sufferer of alcoholism is recognized as one worthy of treatment and rehabilitation.

It may truthfully be noted that drunkenness offenders are arrested and convicted not for alcoholism, the disease, but for drunkenness, the misdemeanor; but what is the misdemeanor if not the most common symptom of the disease? And if the drunkenness offender be indeed a "sufferer of alcoholism," does not Article 2C by recognizing him as "worthy of treatment and rehabilitation," imply that he should be the responsibility of medicine and of public and private health, welfare, and rehabilitation agencies?

The question has not yet been answered in Maryland, and drunkenness offenders continue to go to jail here as in every other state in the union. The facility proposed by the Department of Mental Hygiene, by providing a treatment resource as a possible alternative to the traditional correctional resource, would implement the progressive official position partly stated and partly implied in Article 2C.

The results of the survey of Baltimore City indicate that the habitual drunkenness offenders are a large enough population to warrant a public investment in some attempt to rehabilitate them, especially when consideration is taken of the current cost of "managing" them by repeated arrests, trials, and imprisonments and by welfare support, in many cases, of the untreated alcoholics and their families.*

Baltimore City Statistics

The Baltimore City study was done under the joint auspices of the Baltimore City Health Department and the State Department of Mental Hygiene.

Information on the number and disposition of habitual drunkenness offenders in Baltimore City was collected from four sources: Auditor's Department records (1/1/64-7/1/65) for the number of drunkenness offenders who paid fines and/or court costs; Baltimore City jail commitment records for the same period; interviews with 13 municipal court judges; and Maryland House of Correction records.

Statistical results.—From January 1, 1964, to July 1, 1965, there were 11,340 convictions for drunkenness in Baltimore City municipal courts. These involved 7,176 defendants and resulting in 8,015 jail sentences.

The number of recidivists and their convictions follow:

966	convicted	2 times within 12 months
369	"	3 " " 12 "
175	"	4 " " 12 "
263	"	5 or more times within 12 months

Only six defendants were convicted as habituals and sent to the Maryland House of Correction, and an additional six not convicted as habituals were also sent there. All other jail sentences were to the Baltimore City jail. A total of 148,997 prisoner days was spent by drunkenness offenders in the Baltimore City jail during the 18-month period studied.†

Discussion

These statistics represent only a rock-bottom minimum of the number of habitual drunkenness offenders in Baltimore City. The numbers would be significantly increased, perhaps more than doubled, 1) if the charge of drunkenness were added by the arresting officer when appropriate to such other charges as disorderly conduct, vagrancy, etc.; and 2) if arresting officers routinely checked on previous arrests so as to report as habituals defendants arrested for drunkenness for the fifth time in the previous 12 months.

*According to a projection of the findings of a follow-up study of 378 alcoholic patients of Spring Grove State Hospital, Maryland's estimated 80,000 alcoholics cost the state approximately $6,000,000 per year on welfare budgets.

†Figure on total prisoner days determined by Harry E. Shelley, Coordinator of Alcoholism Programs, Baltimore City Health Department.

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512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

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INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214



Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 10—Post-cesarean Section Death

This patient was a 25-year-old para 1, whose estimated date of confinement was July 15. Her prenatal course had been uneventful, but her pregnancy progressed beyond the estimated date of confinement despite an attempt to induce labor with castor oil and quinine. On August 17, a flat plate of the abdomen revealed a face presentation. The patient was not in labor and the membranes were intact.

A decision was reached to carry out cesarean section. Accordingly, on August 18, under spinal anesthesia using pontocaine and supplemented by intravenous sodium pentothal after delivery, a classical section was done. A living 8lb 3½oz child was delivered.

Her immediate postoperative condition was excellent, and her course proceeded uneventfully until August 20. As the patient was walking to the bathroom, she suddenly fell to the floor and was pronounced dead shortly thereafter. Autopsy revealed massive emboli in both the right and left pulmonary arteries.

COMMENTS

Although pulmonary embolism can occur after normal pelvic delivery, the incidence is greater after operative delivery. Since this was considered an unnecessary cesarean section, the committee voted this a preventable death. With a para 1, with intact membranes, not in labor, the committee members saw no reason for abdominal delivery. It was assumed that the head was not deep in the pelvis and that the chances would have been excellent of spontaneous conversion of the face presentation to a normal vertex early in labor. Accordingly, the decision as to method of delivery should have been postponed until after the onset of labor.

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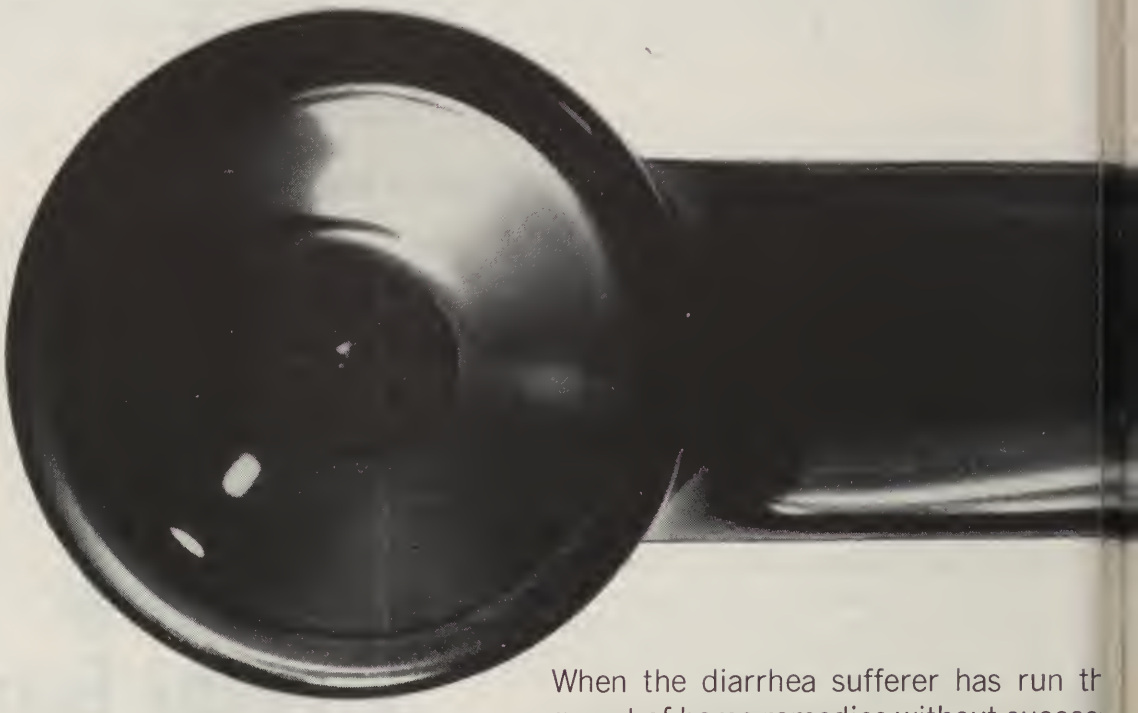
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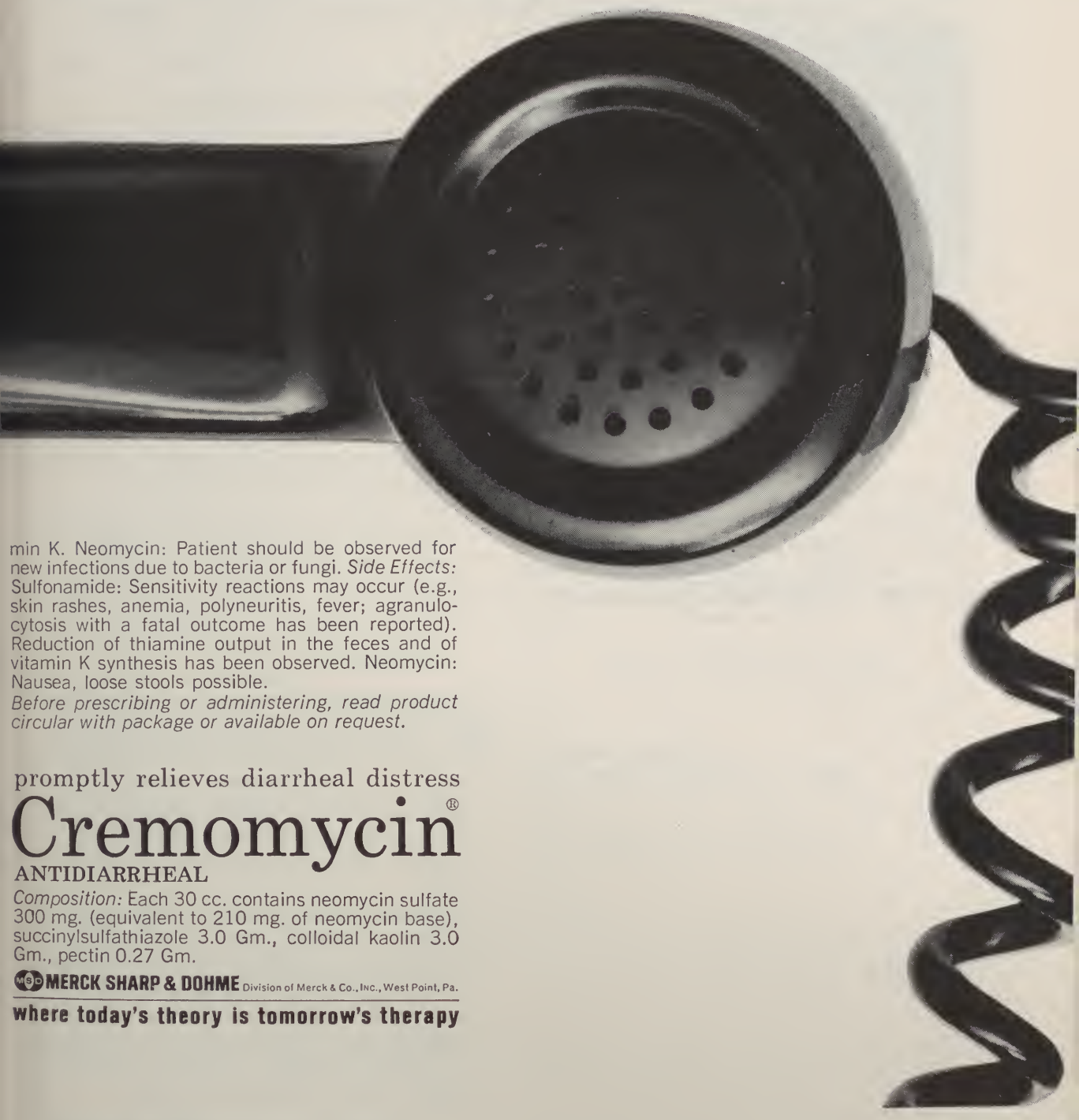


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min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
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Pediatrics

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WILLIAM STIFLER, JR., M.D., Chairman

RAY HEPNER, M.D., Editor

Neonatal Jaundice

MARTIN K. GORTEN, MD

Associate Professor
in Pediatrics and Pediatric Hematologist,
University Hospital

Detection and Management[1, 2]

1. Important to detect early because brain damage may result if jaundice is rapidly progressive and becomes severe.
2. Brain damage due to hyperbilirubinemia is preventable by exchange transfusion (repeated if necessary) regardless of its etiology.
3. Exchange transfusion is indicated if serum indirect bilirubin concentration rises 0.3mg-% per hour or more during first 48 hours of life and is apt to approximate or exceed a level of 20mg% subsequently.

Aids to Early Detection[1, 3, 4]

A. Examine the neonate for jaundice every six hours during the first two days of life.

B. Tag or separate fullterm infants less than 48 hours of age and premature infants under 96 hours of age to be observed for jaundice.

C. Proper lighting (simulating sunlight): two-bulb fluorescent fixture consisting of one deluxe cool white bulb and one standard warm white bulb.

Note: The influence of direct artificial light and light reflected from colored surfaces—yellow light masks jaundice; pink light makes everyone appear jaundice; and blue light blackens jaundice, making detection difficult.

D. Intensity of illumination: a pair of 15 watt bulbs, as under C, held 14-18 inches above baby, or three times the desirable amount of general illumination for a room by ceiling fixtures.

E. Diascopy: Blanche skin with a glass slide or a piece of polished lucite or plexiglas (12 inches long, ¼ inch thick, 1 inch wide). Between examinations, these can be cleaned with a sponge soaked with an antiseptic. "Jaundice rounds" can be made by examining the skin of forehead or cheeks of babies in rapid succession without handling the infants.

Differential Diagnosis[1, 2]

A. Hemolytic Jaundice
  1. Isoimmunization—Rh and ABO erythroblastosis fetalis are commonest.
  2. Acquired
    a. Septicemia—bacterial, viral (see B. 2)
    b. Drug induced such as vitamin K excess, sulfonamides, etc.
  3. Inherited
    a. Hereditary spherocytosis
    b. Heinz body anemia
    c. Non-spherocytic hemolytic anemia
    d. Hemoglobinopathy

B. Non-hemolytic Jaundice
  1. Icterus neonatorum
    a. Transient deficiency of glucuronic acid transferase
    b. Respiratory distress, hypoxia
    c. Maternal diabetes mellitus
    d. Prematurity
    e. Dehydration
    f. Hypothermia
  2. Infections (* denotes possibility of hemolytic component)
    a. Bacterial* (pneumonia, meningitis, etc.)
    b. Cytomegalovirus*
    c. Toxoplasmosis
    d. Syphilis*
  3. Neonatal hepatitis
  4. Inspissated bile syndrome
  5. Atresia of bile ducts
  6. Choledochal cyst
  7. Galactosemia
  8. Familial non-hemolytic jaundice
  9. Crigler-Najjar disease
  10. Large hematomas, internal hemorrhage
  11. Pyloric stenosis (especially posterior hypertrophy)
  12. Cretinism, hypothyroidism
  13. Congenital leukemia
  14. Congenital heart defect

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HUMAN DEVELOPMENT

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The staff at Rosewood has for many years provided the retarded with medical, educational, recreational, and vocational programs.

However, since Rosewood has become a state hospital with its vast increase in the number of patient admissions, there became a need for a more formal, structured program, designed to open the avenues of eventual return to the community.

The Human Development Department was formed in September, 1963, to fill the important parental role in the therapeutic setting, always maintaining the basic philosophy that within each resident's limits there is a potential contribution that can be made to society.

This program includes approximately 660 of the 2,500 Rosewood patients. The majority are court committed because of the inability of the home to cope with the behavior problems. They range in IQ between 50 and 70, in age from 6 to 60, and are mildly or moderately retarded with social and behavioral problems. They live in 11 separate units that house approximately 60 to 70 residents each. The staff consists of 104 psychiatric aides and licensed practical nurses, three supervisors, three cottage administrators, one registered nurse, one secretary, and one director.

Because the primary problems of these residents are neglect, inadequate social adjustment, and undesirable behavior, our program emphasizes constant training in these areas.

Each resident is trained, counselled, and guided in his daily program in personal appearance and hygiene, appropriate behavior, attitude toward authorities and other residents, willingness and ability to carry out assignments, social activities, physical development, home visits, and weekend passes.

An intimate knowledge of each resident is obtained so that all procedures may be coordinated in term of the most effective therapeutic plan for each resident.

Attendant personnel are counseled and directed in handling cottage procedures, non-medical problems, and minor disciplinary measures.

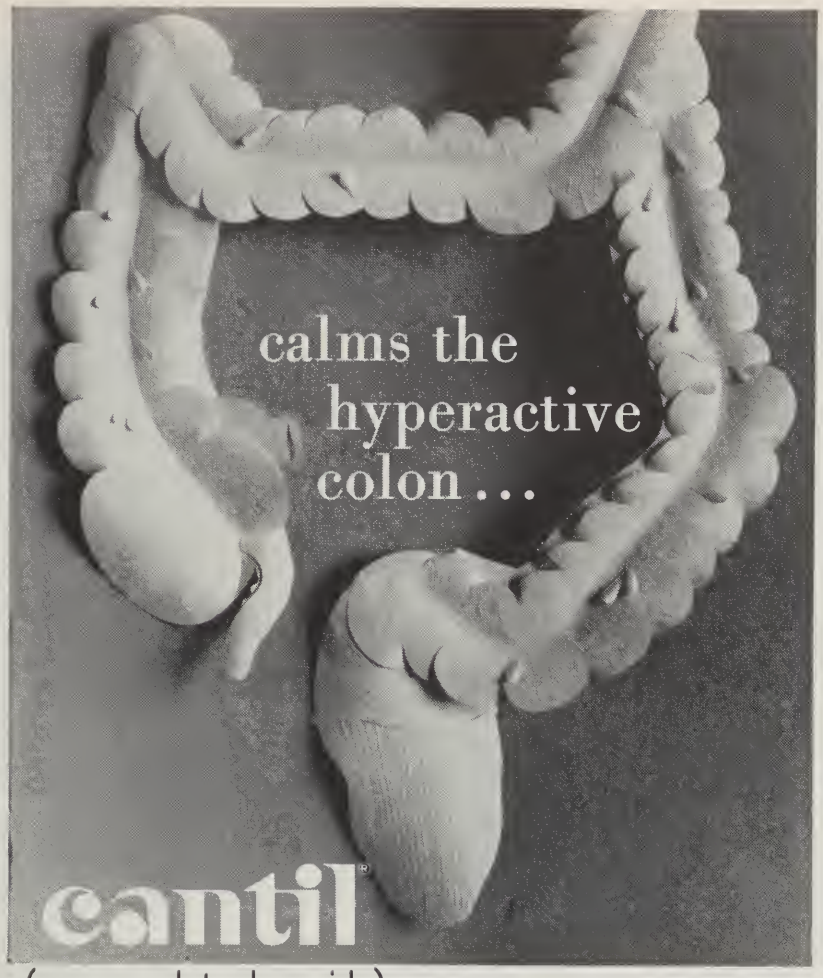
Vocational and industrial therapy programs and recreational programs, designed to further the rehabilitation process of the resident, are coordinated with the Department of Rehabilitation.

Through a system of reward and punishment, the program endeavors to remove those social and behavioral problems not acceptable to community living. Since this is a positive approach, it also implies encouragement where behavior is already satisfactory.

Patient familiarity gained by the Human Development team makes possible a more timely referral to the Social Service Department for community placement and facilitates the task of rehabilitation to a normal social environment.

The recent introduction of a highly structured program in our maximum security buildings has resulted in a vast amount of work being done at the hospital. Residents who have lived for long periods of time in a locked area are being moved to an open cottage where further training has been possible.

Reprinted from *Maryland Steps Ahead,* September, 1965 (a Department of Mental Hygiene publication).



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

Diabetes Detection Drive



Medical and health officials participating in planning this year's diabetes detection drive included, left to right: Dr. Marie Joy Mason, Maryland State Department of Health; Stephen Provenza, Maryland Pharmaceutical Association; Dr. Robert E. Farber, Commissioner of Health of Baltimore; Jack Redfern, Baltimore City Health Department; Dr. Samuel Morrison, president, Baltimore City Medical Society; Dr. A. A. Silver, chairman, Diabetes Subcommittee; Dr. J. Morris Reese, president-elect, Medical and Chirurgical Faculty of Maryland; Dr. Timothy Baker, president, Maryland Public Health Association; Sister Mary Dominic, president, Maryland Dietetic Association; Sister Amelia, chairman, dietetic exhibit, and Mrs. Alice Jean Anderson, dietitian.

During the three-day diabetes detection drive, November 15-17, 3,241 people visited the diabetes detection center in Baltimore for screening tests. Set up in the Fifth Regiment Armory, the diabetes detection center offered other health tests as well. Of these, 1,138 chest x-rays were taken, 1,825 vision tests were made, and 1,033 hearing tests were made.

The diabetes detection drive was sponsored by the Faculty's Subcommittee on Diabetes. Cooperating in testing activities were the Maryland Tuberculosis Association, the Maryland Society for the Prevention of Blindness, the Baltimore Hearing Society, and volunteer groups.

Other participating agencies included the Baltimore City Medical Society, the state and city health departments, the Maryland Diabetes Association, the Maryland Pharmaceutical Association, the Maryland Association of Medical Technologists, and the Maryland Association of Hospital Volunteers.



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



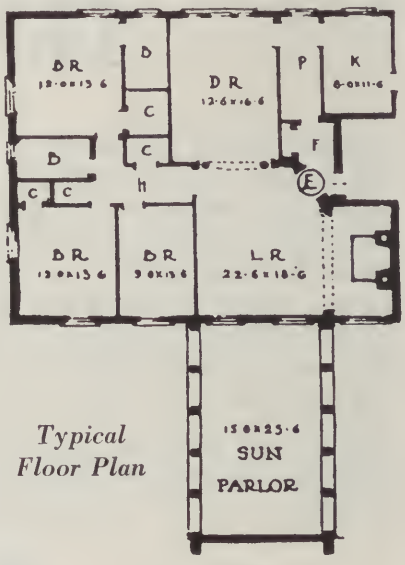
Maryland physicians contributed $9,605 last year to the American Medical Association Education and Research Foundation. Robert vL. Campbell, MD, Faculty president, presented the check to Raymond M. McKeown, MD, president of AMA-ERF, at the AMA's clinical meeting in Philadelphia.

The Garden Apartments

IDEAL LOCATION



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- Easy to reach! From N. Charles St. drive west on 39th Street to Stony Run Lane, then one block right.



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Three bedrooms, three baths; all apartments have three exposures. Living room with fireplace, full dining room, hardwood floors, porch or sun parlor. Fireproof construction of hollow tile and reinforced concrete, stucco covered walls. Luxurious comfort summer or winter.

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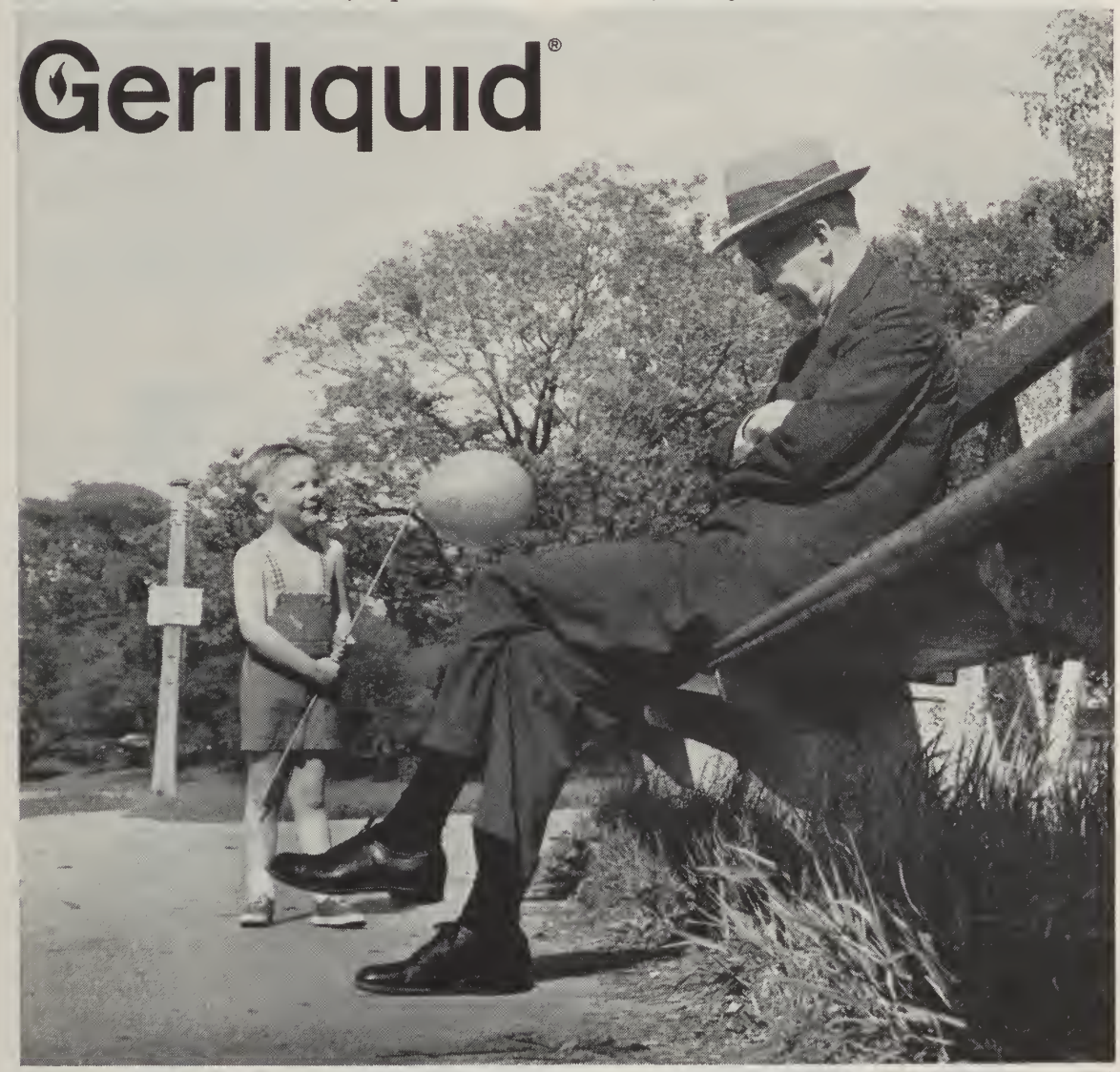
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SA 7-2180

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

DEPARTMENT OF HEALTH

STATE OF MARYLAND

William J. Peeples, MD, MPH, *Commissioner*

Highlights

REVISED REGULATIONS FOR REPORTING COMMUNICABLE DISEASES

The Medical and Chirurgical Faculty and the State Department of Health are collaborating in a campaign to promote more complete reporting of communicable diseases in Maryland, especially of venereal diseases. It was agreed that the mechanics of the system should be modified to make such reporting easier for the busy practitioner.

The revised regulations governing the reporting of communicable diseases have been approved by the Board of Health and Mental Hygiene, and reporting forms are being made available to all physicians through local and state health departments.

Changes have been made both in the list and the manner of reporting. Certain diseases will be reported by numbers instead of by name, and the mailing of reports will be facilitated by a revised card and a self-addressed, postage-paid envelope. It is hoped this new system will produce more adequate reporting of all diseases, particularly syphilis. Although effective methods for its control are readily available, syphilis continues to increase in importance as a public health problem. A solution will come only through the joint efforts of the medical professional and the health department.

PRESIDENTIAL APPOINTMENT

Maryland's Health Commissioner was one of 12 physicians appointed by President Johnson to a National Advisory Council on Regional Medical Programs. The council will advise the Surgeon General on programs created by this year's legislation on heart disease, cancer, and stroke. The council's job will be to discuss various problems of implementation nationwide and to advise the Surgeon General of possible changes required in the program. Part of the council's job will be to consider other types of diseases to see which, if any, need to be added.

HOME HEALTH SERVICES

Meetings with local officials and other interested parties in the health field are being conducted throughout the state to exchange information and ideas regarding the urgent need to develop home health services in connection with the Medicare Act. Central office staff members who will have responsibility for developing these services have participated. A filmstrip describing the Montefiore Hospital (Pittsburgh) home health services program is being used along with our other materials.

DROUGHT AFFECTS WATER SUPPLIES

Several public water supplies have been affected seriously by the continuing drought. One community, Emmitsburg, has been forced to resort to pumping water from a previously unused stream to supplement its usual sources. Because of its location, the water cannot be treated at the filtration plant. The only safeguards will be several days storage and chlorination, requiring close supervision by the Division of Sanitary Engineering. If the drought continues, this same situation may occur in several other communities and will seriously tax the ability of the state and local health departments to provide adequate supervision.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (Iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



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THE NEW RENAULT R-8

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The Automotive Experts at Car & Driver Magazine say: "The Renault R-8 is fast, well constructed, good handling, and has the best brakes in its class." "It has amazing ride & stability." "The Renault R-8 overcomes nearly every traditional objection to economy cars we've ever heard."



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RENAULT

All of the public water supplies in the state are being surveyed to determine the effect the drought has had on their operation and any plans they may have for developing additional sources. This drought, like its predecessors, appears to be having the salutary effect of stimulating the development of adequate sources.

EDUCATIONAL PROJECT FOR INDUSTRY

The Health Department's consultants in nutrition and industrial public health nursing conducted a program on prevention of heat exhaustion at a large industrial plant, in cooperation with the plant's medical, nursing, and safety personnel. Before 1961, when the program began, the incidence of heat exhaustion ranged from 150 to 225 cases each summer. After the health education program was started, the incidence dropped each year and was reduced to five cases in 1965. The nursing consultant, Division of Occupational Health of the U. S. Public Health Service, requested permission to reproduce the project report for use in her training course.

NEW... *from* CAMP

THE CAMP-CULLEN ANKLE BRACE



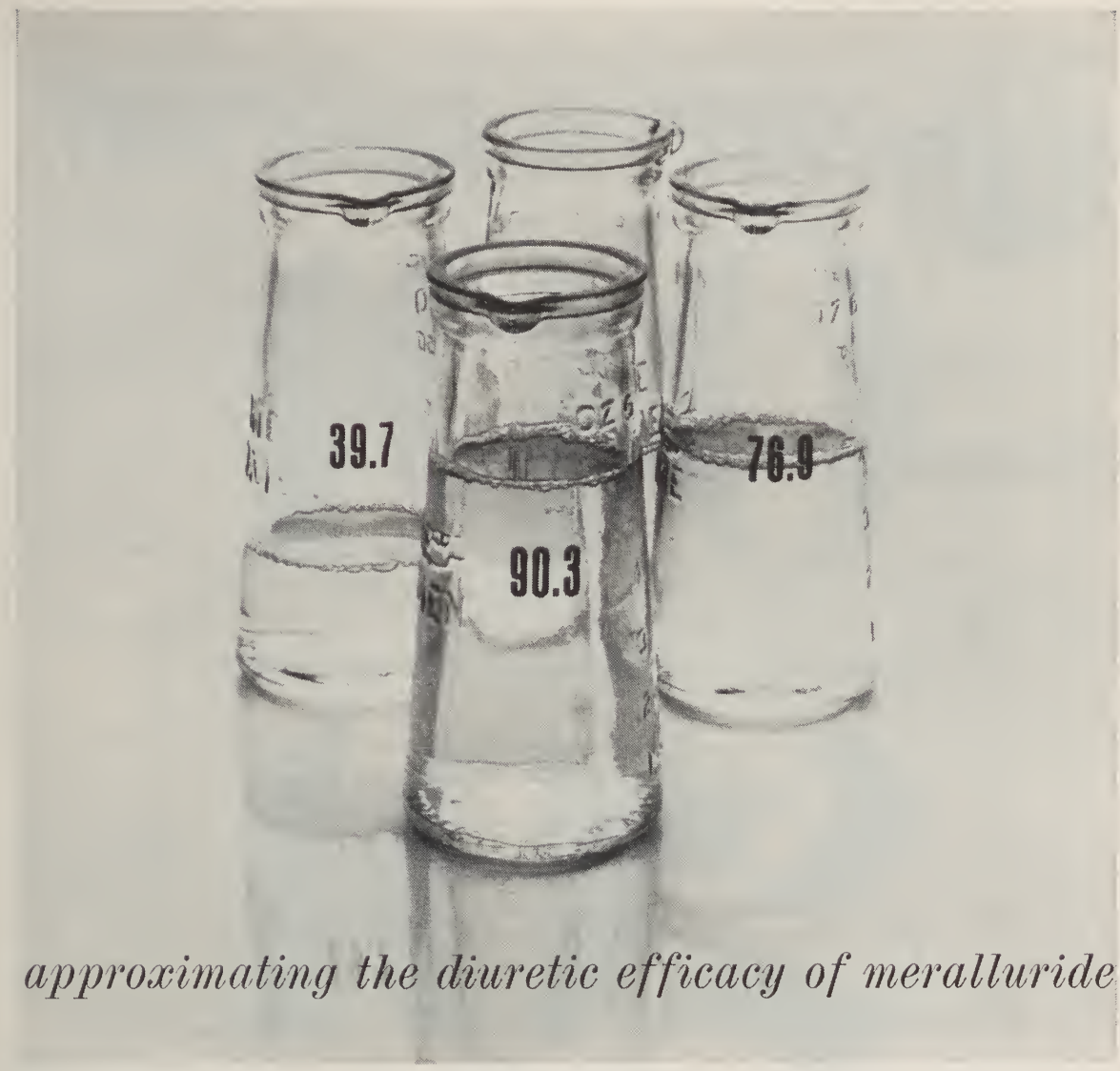
Prophylactic and therapeutic support for active participants in such sports as baseball, football, skiing, tennis . . . this free-flexing device is also a superior aid to recovery from ankle injuries sustained in other ways. Fine flexible plastic-enclosed spring steel wires, covered with nylon, provide the support in a foam rubber and soft twill boot with shoe-type front lacing. Small, medium, and large sizes.

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BALTIMORE, MD.



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

BALTIMORE CITY HEALTH DEPARTMENT

ROBERT E. FARBER, M.D., M.P.H.
COMMISSIONER

American Building, Baltimore and South Streets
Baltimore, Maryland 21202

752-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

VD Darkfield Examination Service

A 24-hour Darkfield Examination Service has been instituted to assist physicians in the prompt diagnosis of infectious syphilis. This service can be obtained within minutes by calling the City Health Department at PL 2-2000, extension 2566. The new service is provided by trained public health representatives who will visit the physician's office at his request and set up a portable darkfield microscope to enable him to make a speedy diagnosis of infectious syphilis.

Under the sponsorship of the Baltimore City Health Department, these public health representatives are also making informational visits to practicing physicians in the city and distributing the latest available literature and treatment schedules for syphilis and gonorrhea.

It is imperative that every case of early syphilis be accurately diagnosed, properly treated, and rapidly reported, preferably by telephone. Rapid and accurate reporting will enable the Baltimore City Health Department to implement thorough epidemiologic follow-up after permission has been received from the reporting physician.

Only through complete physician cooperation can the forces of public health hope to effectively control the venereal diseases in the years ahead. The venereal disease control work of the Baltimore City Health Department is under the supervision of James E. Peterman, MD, director, Bureau of Communicable Diseases.

CALL PL 2-2000, Ext 2566

to obtain prompt Darkfield Examination Service

to report cases of early syphilis

Suicide Study

A preliminary report of the findings on 1,320 suicides occurring among residents of Baltimore City during 1950-1963 has been made by Mr. Sidney M. Norton, director, Bureau of Vital Records, Baltimore City Health Department, and Margaret Bright, PhD, associate professor, Department of Chronic Diseases, Johns Hopkins School of Hygiene and Public Health. A summary of their findings, as reported in the *Baltimore Health News,* is as follows:

1. Of the total suicides, 825 were white males, 305 white females, 141 nonwhite males, and 49 nonwhite females.

2. The trend of the suicide death rate in Baltimore is somewhat upward; in the United States it is slightly downward. The upward trend in Baltimore is due to an increase in suicides among white females.

3. In general, the suicide rate among white people increases with age; no distinct age pattern is evident among nonwhites. Most deaths were in the 35 to 64 age group.

4. Suicides were nearly evenly distributed in the four seasons, with a tendency for more suicides to occur on Mondays. The time of day was unknown in 35% of cases.

5. Most suicides took place within the confines of the city and in the individual's own home, the latter being much more the case for females.

the price of "success"

190
102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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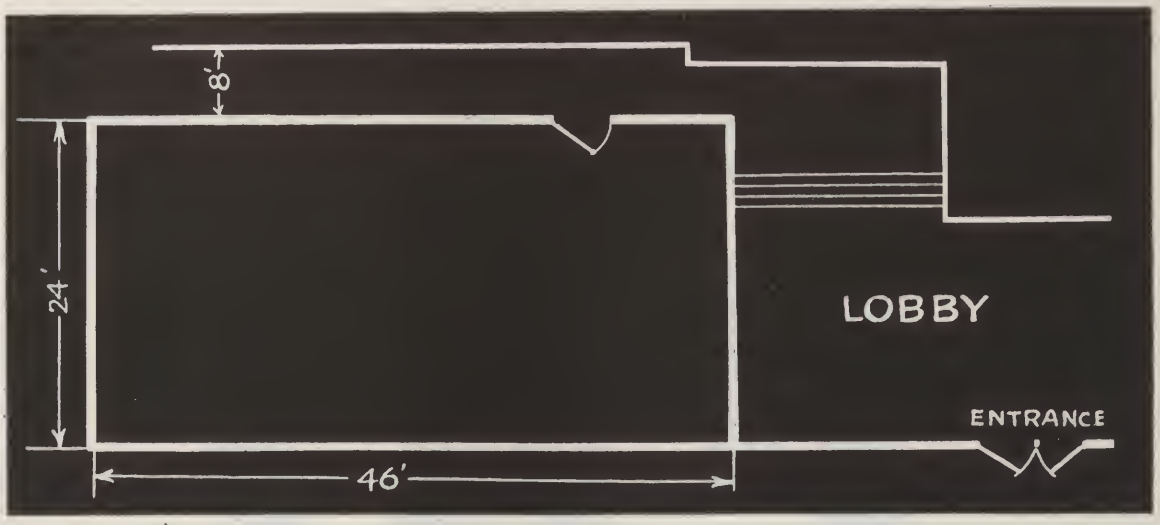
METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

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A modern, air-conditioned, first floor spacious suite like this is available in this beautiful prestige apartment house, centrally located. If, you choose it, you will be the only doctor in the building, on the first floor, right off the lobby. Ideal to share—the rental is realistic, and it includes all utilities, janitorial services, with ample parking, always!

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6. Firearms, poisoning or overdose of drugs, and hanging were the chief means of suicide; females were more likely to use poisons or drugs.

7. More suicides occurred among the widowed, separated, or divorced; occupations did not differ from the population as a whole, but laborers were over-represented among males.

8. The findings suggest that a sizable number of suicides were or recently had been under the care of a physician. One-fifth were reported as having been under psychiatric care at some time. The percentage was considerably greater among white females. Illness was mentioned in over half the cases.

9. There were few indications of "warning signals." Previous suicide attempts or threats of suicide were mentioned in only a small percentage of cases.

10. One suggestion for further research is the need to determine the extent to which a chain of events beginning with illness leads to suicide.

Robert E. Farber, MD
Commissioner of Health

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

STATE OF MARYLAND

Department of Mental Hygiene

Patterns of Retention, Release, and Rehospitalization

Most recently admitted patients are released within a short period after onset of hospitalization, and most of those released do not receive additional hospital services within 18 months after their return to the community.

More than half of the patients in each diagnostic group were released within three months. At the end of 12 months, only 284 of the 1,984 psychotics, 35 of the 626 personality disorders, and 36 of the 1,653 alcoholics were still hospitalized. Eighteen months after admission, half of the psychotics and three-fourths of the personality disorders and alcoholics were alive and not under hospital or clinic care. At this point nine, three, and two per cent of psychotics, personality disorders, and alcoholics remained hospitalized. Roughly twice as many had been released and readmitted.

	Psychotics	Psychoneurotic and Personality Disorders	Alcoholics
Percent Released Within			
3 Months	55	79	84
6 Months	74	90	93
12 Months	85	94	97
For Those Released Within 12 Months, Percent Rehospitalized Within			
3 Months	17	15	19
12 Months	37	28	37
18 Months	45	32	42
Status 18 Months After Admission (Per Cent)			
In Hospital — Continuously	9	3	2
Readmitted	13	6	6
On Hospital Leave	14	6	5
On Clinical Rolls	15	9	3
Dead	2	2	5
Alive—not under care	47	74	79

The following data, from a recently released study,* are based on 4,263 admissions, age 25-54, to the Crownsville, Springfield, and Spring Grove Hospitals between July 1, 1961, and December 31, 1962. Of these, 1,984 were diagnosed as psychotics, 626 as psychoneurotic and personality disorders, and 1,653 as alcoholics.

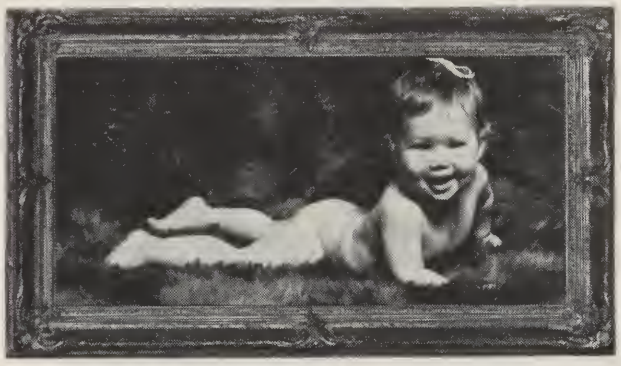
These data indicate that the build-up in the number of chronic long stay hospital patients

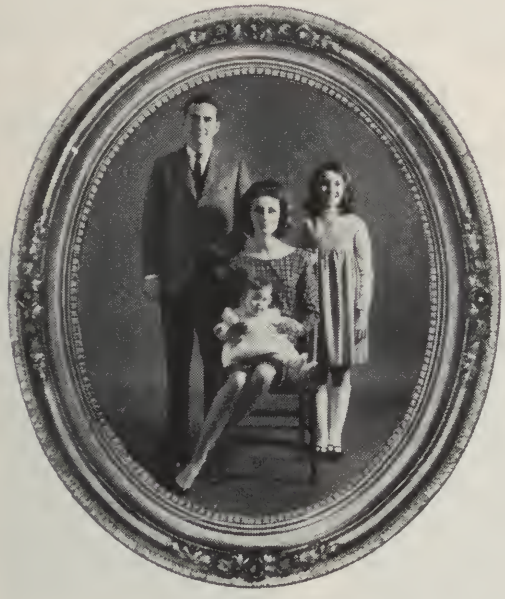
*A Psychiatric Case Register Study Of Release And Return Rates For State Mental Hospital Patients—Presented at the annual meeting of the American Public Health Association on October 18, 1965.

Turn a bundle of colic



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is small, even for those with psychotic disorders. Should this continue, we can anticipate that the accumulation of patients hospitalized continuously for long periods of time will be exceeded by the number released or dying with a resultant gradual decline in the size of this chronic patient cohort. Further efforts to minimize chronicity depend on the application of new and improved treatment concepts and on the close coordination of all hospital and community services and facilities.

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Sometimes it is easier to answer the question, "Dad, may I have several thousand dollars for a college education?" than it is to answer, "Dad, may I have several hours of your time for advice about my future?"

While this may seem irrelevant to professional business management, many factors which business advisors must keep in mind are common among physicians: 1) how the doctor can earn enough to adequately provide for the needs of himself and his family; 2) how the doctor can help guide the family future as bread winner, husband, father, and friend.

These responsibilities, while shared by people in other professions, are complicated by the demanding outside forces (such as hospital, clinics, societies) which few other professions encounter. Where to draw the line and divide the time is the crucial problem.

Take the following case as an example of the complexity of the problem:

Dr. Post's son finished high school with good grades and has recently completed his second year of college with fair grades. Fred walked into the house one evening and announced at dinner, "Dad, Mom, I joined the Marines; leave Monday a week. No sense in arguing; it's done." Shock came over both parents. Two years' money down the drain for college was one thing, but three years of his future lost to the Marine Corps was another. All the family reasoning in the world couldn't change his mind. His father finally suggested that Fred at least talk to someone of similar experience. Fred talked to a former Marine sergeant and learned that while the Marine Corps certainly offered many advantages in learning discipline and self-protection, the chances for developing a career in medicine (even at Officer's Candidate School) were slim. The Marine Corps was the worse possible choice, and after a few days of serious thinking, Fred altered his plans and is glad of it.

Need anyone tell you that there is no greater emergency than seeing to the well-planned future of your family. The economic factor, while tremendously important, is completely insignificant to the personal attention factor.

The impression should not be gained that all physicians are too busy or for other reasons reluctant to give their family adequate attention. Appraise your own situation by the following guidelines:

1. Should you recognize that you have not been giving your family adequate time and attention, MAKE THE TIME!
2. If you feel you have given enough time and attention yet your advice is not being accepted, seek the assistance of a friend completely removed from the family but one who has direct insight and experience in the immediate problem.
3. If you have given your time and attention or you have sought outside assistance yet neither is accepted, then rest assured with a clear conscience that you have done all that you can do as a parent.

Ignore any member of your family and you'll create a future stranger.



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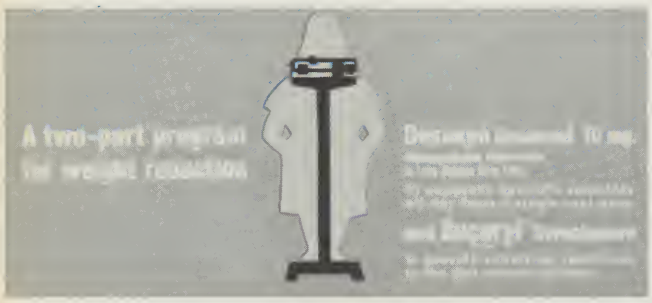
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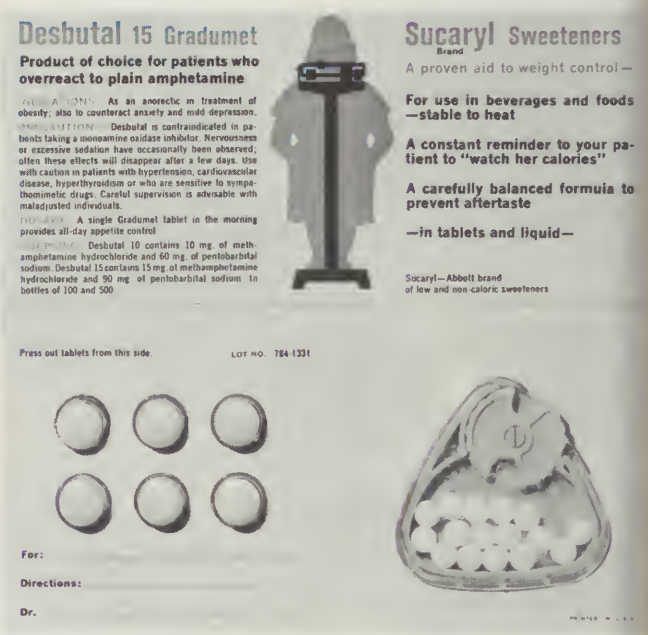
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A number of our members are unaware of the interlibrary loan program. When a member requests a book or journal article from the library, we first check our own holdings for it. If we do not own the requested material, we then attempt to locate it locally. There are several sources, including Health Sciences Library of the University of Maryland, Welch Medical Library and Phipps Psychiatric Library of Johns Hopkins University, Johns Hopkins University Library, Enoch Pratt Free Library, and various hospital libraries.

When material is not available locally, it is then requested from the National Library of Medicine (NLM) in Bethesda. The interlibrary loan service is quite prompt and free! Usually a requested book is received within two weeks. Most of our requests from NLM are for journal articles. A single photocopy of the article is sent instead of the original, usually within five to 10 days, and need not be returned. Last month we requested an article from NLM which had been published in 1772. A photocopy was received within 10 days.

There are, of course, many other sources for information. If you desire an article or a book, even though you think that our library does not own it, let us know so that we may take advantage of the interlibrary loan program.

This program works two ways. We also lend books and journals to libraries both local and out-of-state. Even the National Library of Medicine borrowed two items from us this year!

* * * * *

To continue our book review series, John D. Dumler, MD, a gynecologist, gave us his thoughts about the following book:

APPLIED HYPNOSIS AND POSITIVE SUGGESTION, by George A. Ulett, MD, and Donald B. Peterson, MD, C. V. Mosby, 1965.

This recently published, short, concise, and informative book concerning hypnotism and suggestion should be well received by all clinicians interested in those aspects of medical therapy which deal with psychosomatics. It is not comprehensive enough to delve very deeply into the numerous theories of hypnotism; it does not catalog the many oft-raised, although possibly erroneous, objections to hypnotism. It limits its scope to the more easily treated conditions of outpatients, and it barely touches upon the application of suggestibility to the surgical and obstetric fields. It does whet the appetite for more. As far as it goes, it is practical rather than theoretic. This is a virtue in that it may stimulate the practitioner to try to treat the office patient more adequately with psychotherapy. Suggestion and reassurance are wonderful tools.

The book's weakness is that it is too facile. It suggests that hypnotism is easily learned and simply applied. Most busy practitioners have not the patience to try, and their motivation is diminished by early failures.

The book serves one purpose nobly. It takes



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suggestion out of the mysterious and places it in a well-defined therapeutic niche, devoid of symbolic trappings. It is well worth reading twice.

Recent Accessions

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U. S. Congress, Senate, Special Committee on Aging: *Health frauds and quackery.* U. S. Govt. Print. Off., 1964.

Yearbook of anesthesia. 1965/66.

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February, 1966

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Mrs. James A. Roberts

President, Woman's Auxiliary to the Montgomery County Medical Society



Mary Adele Roberts was born in Baltimore. After graduating from the Institute of Notre Dame, she went into nurses training at Mercy Hospital. She received her RN in 1947.

While a student at Mercy Hospital, Mary Adele met James A. Roberts, an intern. They were married in 1948 and moved to Jacksonville, Fla., where he was stationed as a medical officer at the naval air station. They returned to Baltimore in 1949, where Dr. Roberts had an assistant residency in medicine at Mercy Hospital for one year and a fellowship in medicine at Johns Hopkins Hospital for two years. In July, 1952, they moved to Silver Spring, and Dr. Roberts started his practice in internal medicine.

Mrs. Roberts did private duty nursing in Baltimore and general nursing at St. Vincent's Hospital in Jacksonville. When she returned to Baltimore she worked in the operation room at Mercy.

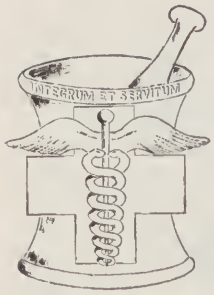
Mary Adele was treasurer of the Woman's Auxiliary to the Montgomery County Medical Society from 1954 through 1956. She became president-elect and chairman of the AMAERF in 1964 and was installed as president on May 18, 1965. She is a member of three PTA's, the auxiliary to the Holy Cross Hospital, church organizations, and Manner Country Club Swimming Committee.

Dr. and Mrs. Roberts have seven children: Pat, 16; Bill, 14; Nancy, 12; Peggy, 9; Frank, 8; Michael, 7; and Mary Beth, 4.

Mary Adele's hobbies are swimming, golf, bowling, knitting, and sewing. She enjoys travel, and she and Dr. Roberts are looking forward to the Bermuda Cruise with the Med-Chi in April.

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Additional attractions of the evening will be drawings for valuable prizes as well as the usual cheer baskets. After the performance, the guests will be treated to homemade pastries and coffee plus cordiality and good company. Tickets are $3 if purchased in advance or $3.50 if purchased at the door.

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Book Reviews

Clinical Phonocardiography, Dennis C. Deuchar, MD, Princeton, NJ: D. Van Nostrand Co, Inc., 1965.

In the preface to this small book, the author states that his aim ". . . has been to provide for the general physician or practitioner and the student, whether post- or under-graduate, a relatively short text which will serve to familiarize him with the potentialities and current usage of the phonocardiograph." Included are sections devoted to instruments and techniques, principle abnormalities of heart sounds and murmurs, interpretation, and phonocardiographic patterns in various diseases and states.

The author has made free use of explanatory and illustrative diagrams with approximately 80 figures, including many tracings drawn and to some extent simplified. There are also eight plates or reproductions of phonocardiograms. The illustrations and text are well done. At a time when cardiac auscultation has received impetus from careful correlations with results of cardiac catheterization and other hemodynamic studies, this text fills the need for a relatively simple book, bringing to the practicing physician and student the practical advances in cardiac auscultation.

The presentation combines a well integrated text with excellent illustrations. It is recommended as one of the finer simpler texts in this area to both student and practicing physician alike.

Leonard Scherlis, MD

PRINCIPLES OF CHEST ROENTGENOLOGY, by Benjamin Felson, MD, Aaron S. Weinstein, MD, and Harold B. Spitz, MD. Saunders, 1965.

This is a programmed text designed to give the nonradiologist a basic understanding of chest roentgen interpretation. The programmed format, based on material from a more conventional text, introduces the subject simply and with a minimum expenditure of the student's time. The authors have written in a light, informal style, with bits of humor, to further ease the student's burden.

SYMPOSIUM ON FOODS: PROTEINS AND THEIR REACTIONS, edted by H. W. Schultz, PhD, and A. F. Anglemier, PhD, AVI Publishing Co., 1964. $3

The Symposia on Foods, conducted by the Department of Food Science and Technology, Oregon State University, bring together scientists engaged in research not necessarily related to foods and scientists who are conducting research on food systems. They focus on problems believed to be given too little attention. This report calls attention to the need for more knowledge of the role of foods in allergies, immunity, and the least explored aspects of nutrition.

THE UNIVERSITY OF MIAMI NEURO-OPHTHALMOLOGY SYMPOSIUM, edited by J. Lawton, MD, Thomas, 1964. $16.75

This symposium, held in 1963, makes available to the practitioner some of the newest clinical information on the subject, some of which is published in this volume for the first time. Among the subjects presented are ophthalmodynamometry, skew deviation, ischemic optic neuritis, bright plaques of Hollenhorst, and the importance of the treponema pallidum immobilization test in the diagnosis of ocular and neurosyphilis. Surgical treatment of intracranial vascular lesions, such as aneurysms and arteriovenous malformations, is thoroughly reviewed.

Among the contributors are Richard Lindenberg, MD, and Frank B. Walsh, MD, of Baltimore.

EXPERIENCE IN RENAL TRANSPLANTATION, by Thomas E. Starzl, MD, Saunders, 1964. $17

While clinical application of organ transplantation is far from perfect, the fact that four of the first six patients in this series are still well attests to the progress that has been made. The author presents a simple and practical analysis of cases treated by renal transplantation at the University of Colorado Medical Center.

CURRENT CONCEPTS IN MEDICAL PRACTICE, edited by John E. Mullins, MD. Mosby, 1965. $10.75

This book is the editor's solution to the medical literature explosion. It is an attempt to summarize recent developments without exhausting either the subject or the reader. Only common medical problems are considered here, and selections from the literature of the past two years highlight each of the subjects discussed. Each section is well documented.

RYPIN'S MEDICAL LICENSURE EXAMINATIONS, 10th ed, edited by Arthur W. Wright, MD. Lippincott, 1965. $12.50

Like its predecessors, this edition offers a compact, concise, and orderly presentation of the various fields of medicine as an aid in reviewing for licensure and other examinations. It is divided into two broad areas: Basic Medical Sciences and Clinical Sciences. All chapters have been brought up to date.

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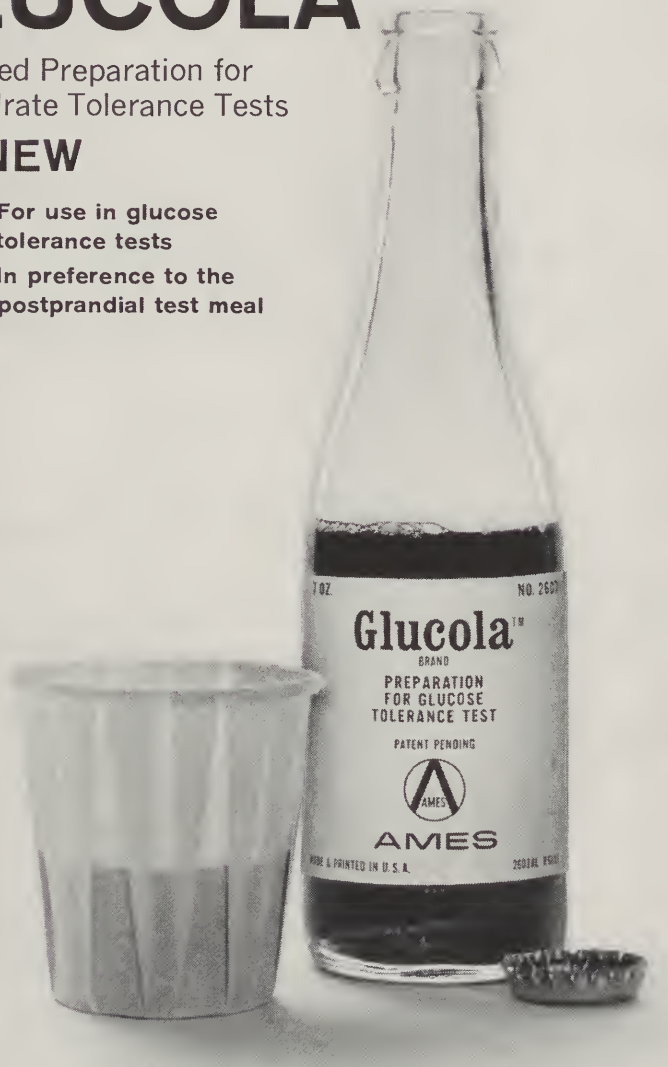
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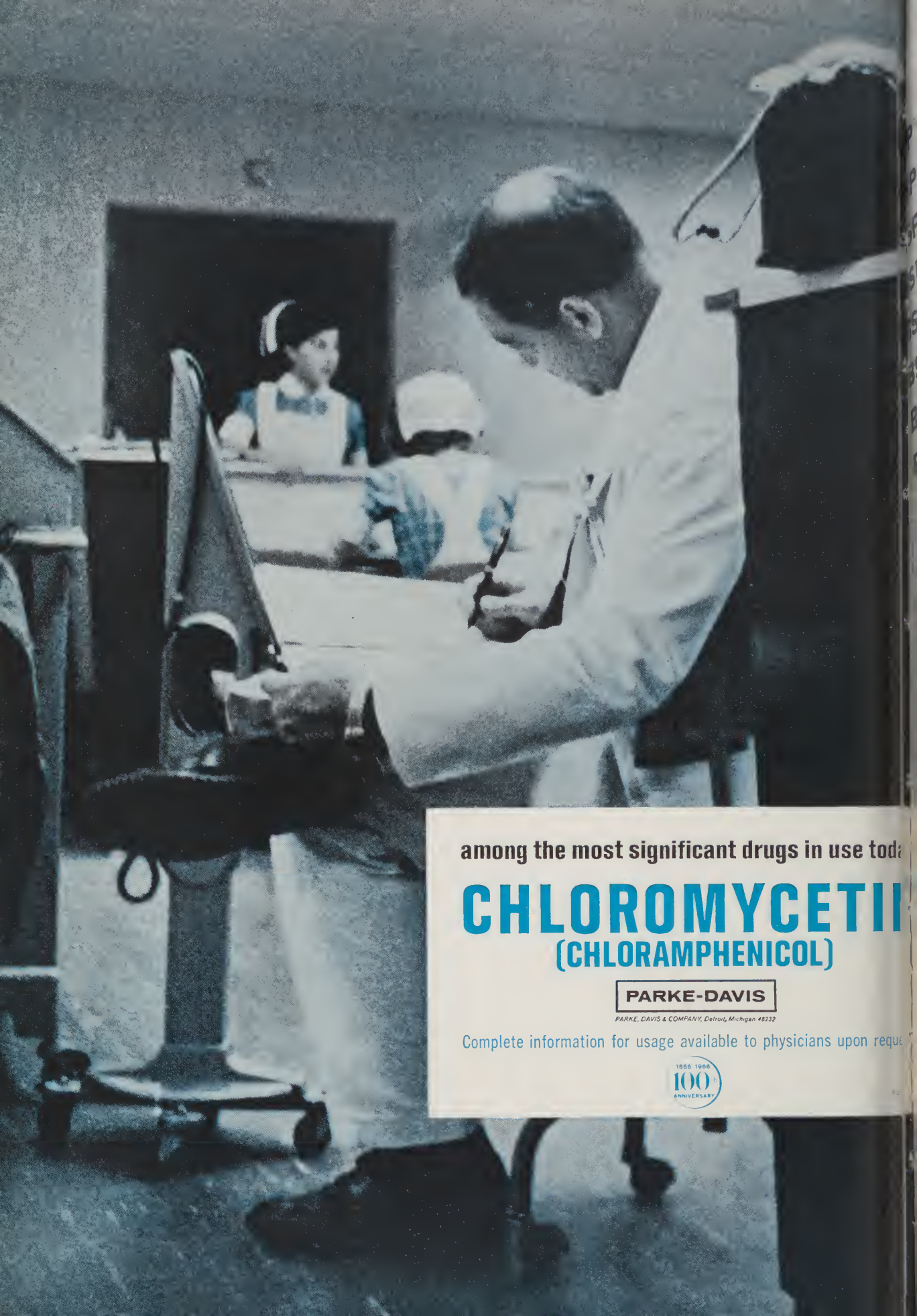
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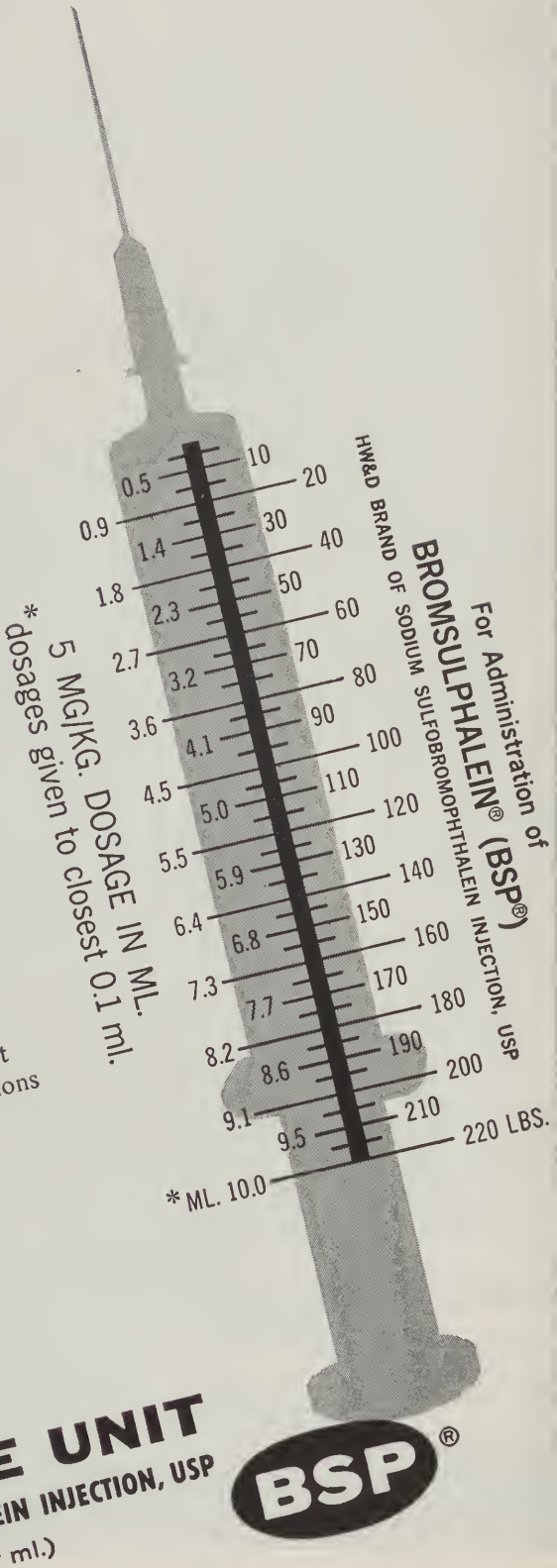
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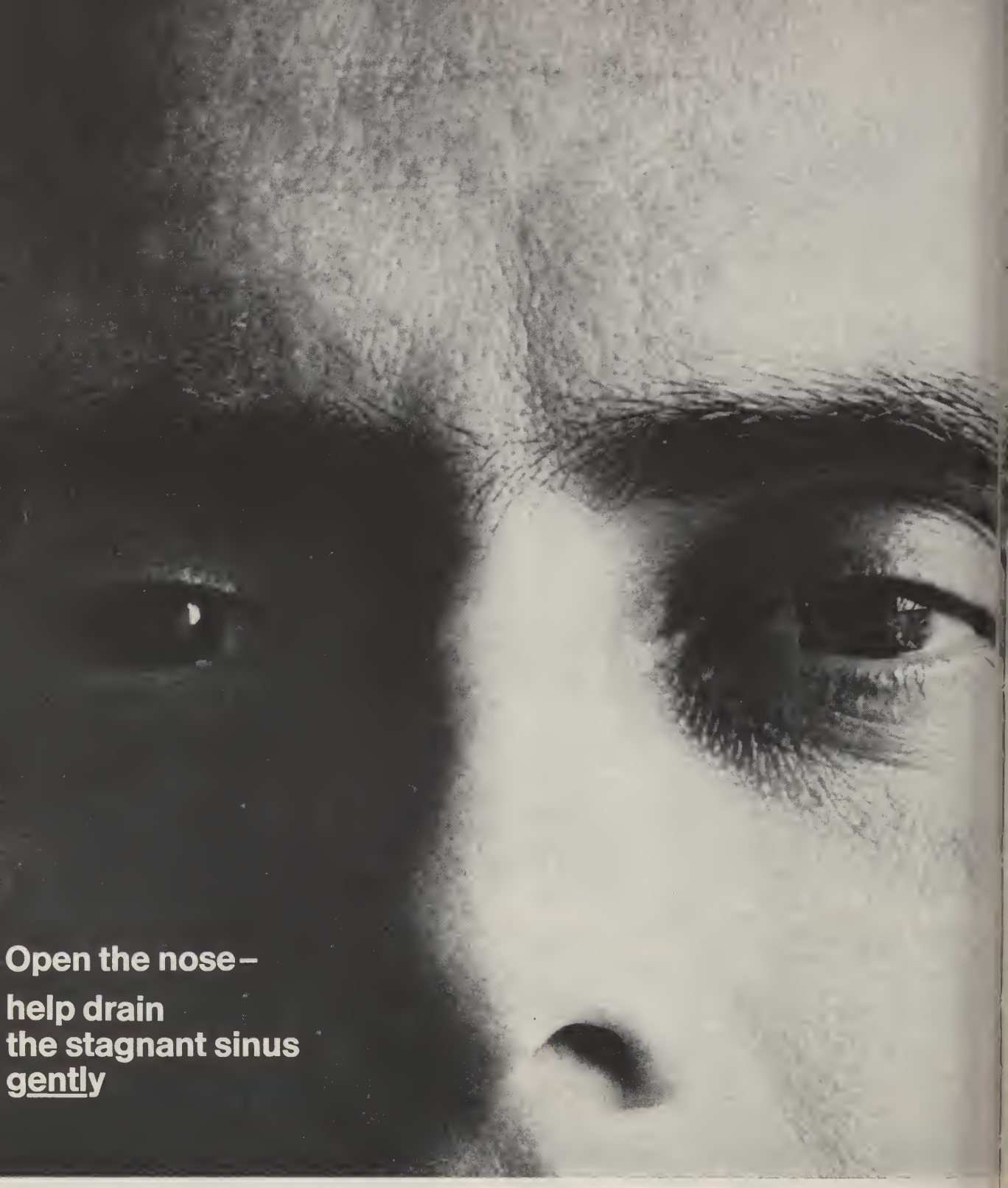
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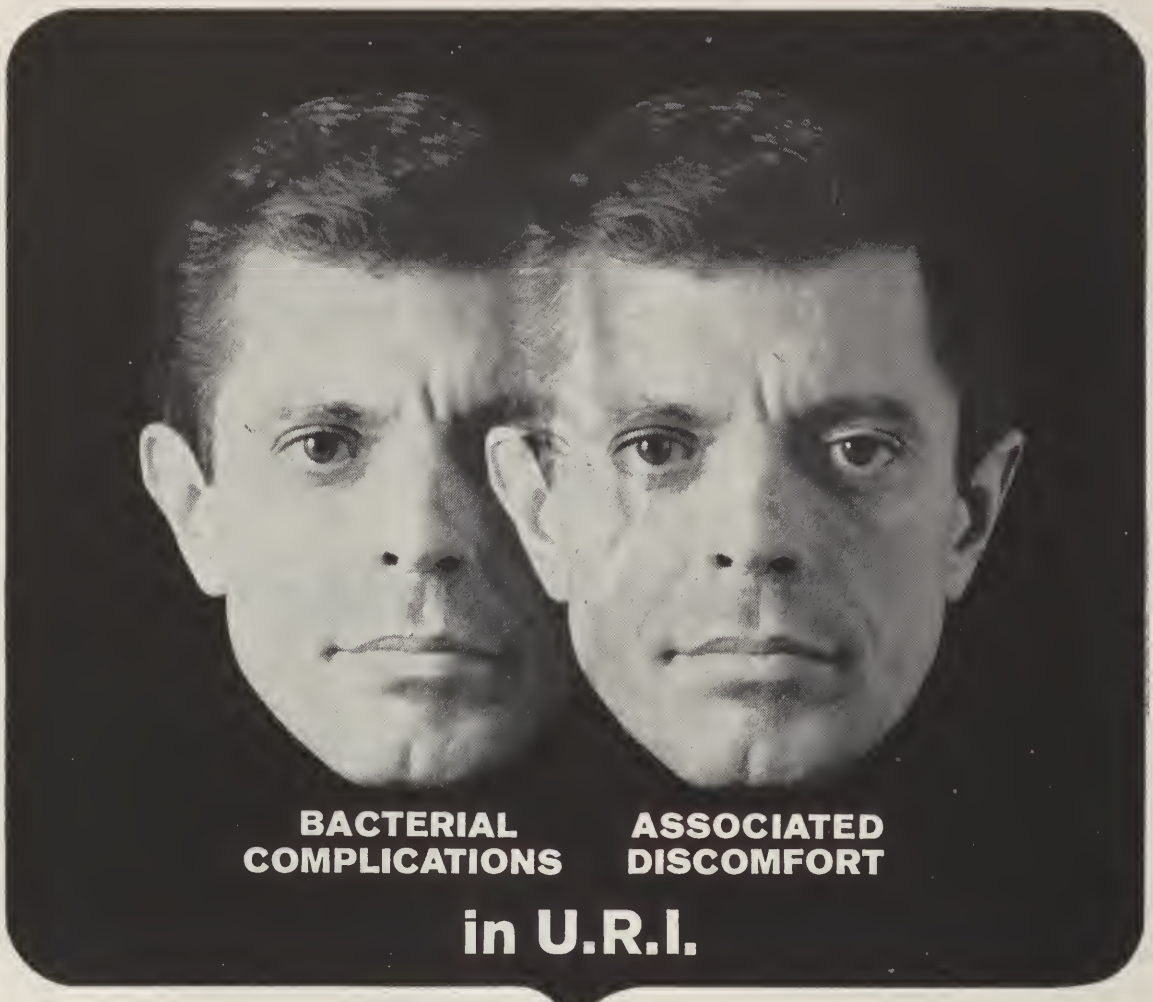
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April 27-May 4, 1966—Annual meeting, Medical and Chirurgical Faculty of the State of Maryland.
April 27-28, Baltimore—April 29-May 4, Aboard ship and in Bermuda
See program Pages 66-67

MEDIC PROGRAMS

March 25—1-2 PM

From Frederick Memorial Hospital: "Hemolytic Anemia," William H. Zinkham, MD.

April 1—12:30-1:30 PM

From University Hospital: "Chronic Bronchitis and Emphysema," David G. Simpson, MD.

April 8—12:30-1:30 PM

From The Johns Hopkins Hospital: "Headache," William G. Speed, III, MD.

April 15—12:30-1:30 PM

From The Johns Hopkins Hospital: "Systemic Lupus: A Not Uncommon Disorder," Philip A. Tumulty, MD.

April 22—1-2 PM

From Frederick Memorial Hospital: "Leukemia," Edward S. Henderson, MD.

You may hear these programs in the Faculty auditorium or at one of the participating hospitals (see Page 128).

MARYLAND EAR, NOSE AND THROAT SOCIETY

March 22—Sheraton Belvedere Hotel, Baltimore

6:30 PM—Cocktails and Dinner
8 PM—"Epistaxis With Particular Reference to Ligation," J. Ryan Chandler, Jr., MD, professor of otolaryngology, University of Miami Medical School.

MARYLAND SOCIETY OF INTERNAL MEDICINE

March 28—8:15 PM—1211 Cathedral St., Baltimore

Joint meeting with BCMS Section on Internal Medicine. Thaddeus E. Prout, MD, speaker.

MARYLAND OPHTHALMOLOGICAL SOCIETY

March 31—Sheraton Belvedere Hotel, Baltimore

6 PM—Cocktails
7 PM—Dinner
8 PM—"Ultrasonics in Ophthalmology," Arthur H. Keeney, MD, Wills Eye Hospital, Philadelphia.

BALTIMORE CITY MEDICAL SOCIETY

April 1—8:30 PM—1211 Cathedral St., Baltimore

Semiannual business meeting.

April 4—8 PM—Sinai Hospital, Baltimore

HEART ASSOCIATION OF MARYLAND

Cardiovascular Forum: "Peripheral and Cerebral Arterial Insufficiency."

April 4-8—Roanoke, Va

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Thirty-ninth annual spring congress in aphthalmology and otolaryngology. For further information, write: Superintendent, Post Office Box 1789, Roanoke, Va.

April 5—7:30 PM—1211 Cathedral St., Baltimore

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

Business meeting.

April 13—Sheraton Belvedere Hotel

BALTIMORE CITY DENTAL SOCIETY

"The Philosophy and Rationale of Replacement Dentistry."
3 PM—Dr. Louis Fox
6 PM—Cocktails and dinner
7 PM—Dr. Harry Levin, president, Maryland State Dental Assaciation
7:30 PM—Dr. Louis Fox

April 14—8:30 PM—1211 Cathedral St., Baltimore

MARYLAND PSYCHIATRIC SOCIETY

"The Promise and Limitations of Group Therapy," James Mann, MD, director, resident training; professor of psychiatry, Boston University School of Medicine. Discussant: Theodore M. Feldberg, MD.

April 13-16—White Sulphur Springs, WVo

W. VA. ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Nineteenth annual meeting, to be held at The Greenbrier. For further information write to J. Elliott Blaydes, Jr., MD, Secretary-Treasurer, 107 Federal Street, Bluefield, W. Va.

April 14—Frederick County

FREDERICK COUNTY HEART ASSOCIATION

Nurses symposium.

April 21—Frederick County

Medical workshop.

April 15

HEART ASSOCIATION OF THE LOWER EASTERN SHORE

Teaching sessions for physicians: "Arrythmias," Henry J. Marriott, MD.

April 18—8 PM—1211 Cathedral St., Baltimore

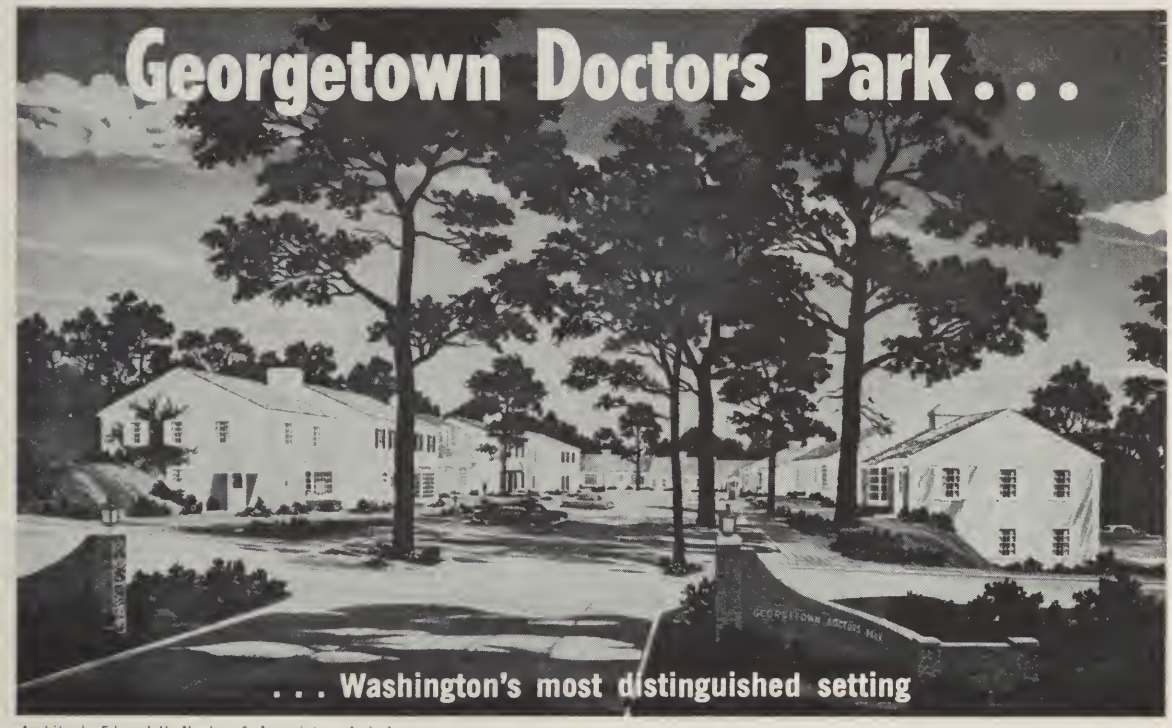
PATHOLOGY SECTION BCMS

Talk followed by presentation of cases, William H. Hartmann, MD, moderator.

April 19—5:30 PM—Sheraton-Baltimore Inn

MARYLAND RADIOLOGICAL SOCIETY

Dinner meeting ond residents' papers.



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JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, JANUARY 6

1. Appointment of A. Gibson Packard, MD, to the Advisory Committee to Maryland Statewide Study on Vocational Rehabilitation was approved.

2. An increase in the Board of Medical Examiner's rental charge for Osler Hall, for use during examinations, was approved effective with the 1967 budget.

3. The Committee on Postgraduate Education, Preventive Medicine, and Public Health was designated to work with the State Health Department in defining "areas of need," under Senate Bill 667 (providing scholarships to medical students who agree to practice general medicine in areas of need for a period equal to the years of scholarship.)

4. The Liaison Committee was designated to meet with the State Health Department in connection with regulations defining who should qualify for free laboratory services from the Health Department.



11:47 pm 11:53 pm 12:06 am

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5. The following policy was adopted for dues checks which are received without payment of the assessment: First, a letter is to be written advising the physician that the dues check cannot be processed until the $50 assessment is received. In 10 days, if no check or reply is forthcoming, the dues check is to be returned to the physician with a letter advising that failure to pay dues and assessments will result in loss of privileges and eventual suspension from membership, in accord with the procedure spelled out in the Bylaws. A copy of this letter is to be sent to the physician's component society.

6. The Executive Committee considered various recommendations of the Legislative Committee and will recommend to the Council that the Faculty take the following position on forthcoming legislative proposals:

1) Oppose nurse-midwife legislation, as this would give to such practitioners hospital privileges which are denied to qualified medical personnel
2) Support changes in the physical therapy law which would a) exempt from licensure those persons engaged in an approved course of instruction, and b) increase the membership on the Board of Physical Therapy Examiners to include five physicians and two licensed physical therapists, all to be appointed by the Governor from a list submitted by the Faculty
3) Oppose the principle of license exemption for dentists, veterinarians, and others when performing medical acts in times of emergency, as this privilege already exists
4) Support and introduce amendments to battered child legislation as proposed by the Subcommittee on Child Welfare and agreed to by other interested groups
5) Oppose premarital STS law
6) Support proposed rewritten Nurse Practice Act



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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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EXECUTIVE SECRETARY'S NEWSLETTER

March, 1966

ESOLUTIONS INTRODUCED

Resolutions to be considered at the Annual Meeting of the Medical and Chirurgical Faculty on Friday, April 29, include:

1A/66 - Endorsing Policy of Separating Professional Fees from Hospital Charges

2A/66 - Urging Establishment of a Formal School of Medical Technology at the University of Maryland in a manner analogous to that of the Schools of Medicine, Dentistry and Pharmacy; and Urging the State Legislature to appropriate a minimum of $50,000 to establish it; and to provide that it award the B.S. degree.

Copies are available to Faculty members through the Faculty office.

EFERENCE COMMITTEE

The Reference Committee meeting is scheduled for

THURSDAY, MARCH 31, at 8:00 p.m.

in the Faculty Building, in order to hear interested parties comment on the above resolutions.

All Faculty members are urged to attend and express their opinions on these matters.

ERSONALITIES

Byron G. Brogdon, M.D., Baltimore, has been named a Fellow of the American College of Radiology.

Chin-Hsin Lin, M.D., Baltimore and Arthur Peschin, M.D., Potomac have been certified as Fellows of the American College of Anesthesiologists.

ELCOME BACK

We are pleased to welcome back The Upjohn Company as an advertiser in the Maryland State Medical Journal. We also welcome two new advertisers: Pitman-Moore and Walker Laboratories.

HOTEL RESERVATIONS

The Sheraton-Belvedere Hotel has a block of 50 sleeping rooms set aside for those who are attending the Annual Faculty meeting, April 27-29, 1966. As these accommodations will be at a premium during this period, members are urged to obtain their reservations early.

BERMUDA CRUISE

The cabins remaining on board the SS Argentina, sailing from Baltimore, April 29, 1966, from the Dundalk Marine Terminal, are fast disappearing. For those who wish to participate in this five-day cruise to Bermuda and return, contact should be made immediately to:

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COUNCIL AND HOUSE MEETINGS

An alert for now. The House of Delegates will meet in session on

TUESDAY EVENING, APRIL 26, 1966, at 8:00 p.m.

and again on

FRIDAY MORNING, APRIL 29, 1966, at 9:30 a.m.

both at the Faculty Building. This change in schedule is made so as to leave ample time for members to sail Friday afternoon to Bermuda.

A gala cocktail party is being given aboard ship, courtesy Moore-McCormack Lines and Travel Guide Agency, starting at 1:30 p.m. on Friday. All members are cordially invited to attend.

The Council will meet immediately before the Tuesday night session; and immediately following the Friday morning session.

NEWS NOTES

Wilmer K. Gallager, Jr., M.D., Baltimore, has been certified by the American Board of Internal Medicine.

John Sargent

Executive Secretary



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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

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Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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Maryland State Medical Journal
Vol. 15, No. 3
March, 1966

Editorial

The Mores of Medical Practice

Disagreeable, disgusting, disappointing, disenchanting and disheartening situations

The worst sin towards our fellow creatures is not to hate them, but to be indifferent to them: that's the essence of inhumanity.

—George Bernard Shaw

JOHN H. HIRSCHFELD, MD

Quoted from the *News American,* Louis Azrael's column of October 8, 1965:

A Lady-on-the-Phone said . . . "I'm an alcoholic and I need a doctor. I don't want to go to a public clinic. And I can well afford to pay a doctor. I called Alcoholics Anonymous and asked if they could recommend one. They said they don't do that. I called the Baltimore Council on Alcoholism. They also refused to recommend anyone. I called Johns Hopkins Hospital. They told me to go to my family doctor. But I haven't got a family doctor because I haven't been in Baltimore long, and, fortunately, have had no other illness. So what am I supposed to do. You'd think that with so much publicity about the need to help alcoholics, somebody ought to tell an alcoholic where there's a doctor who can deal with the problem."

This column was answered a few days later and is cited here:

Dear Mr. Azrael:

I read your column of Friday, October 8, 1965, wherein you quoted a lady alcoholic who had called you on the telephone stating that she wanted a doctor to help her with her illness.

Since three days before a Mrs. J. called me and related practically the same story, and then claimed to have been referred by you to the Medical and Chirurgical Faculty (LE. 9-0872). I firmly believe that this is the same lady with whom I had a long and animated conversation. She bitterly complained that she had fruitlessly called 14 different agencies, and asked personal questions of this physician, trying to assure herself of my full sympathy. After reassuring her of my full understanding of her problem, telling her that I would give her all the time and patience I could, provided she was sincerely motivated to stop drinking, and giving her a definite appointment on my next office day, this anxious lady never kept her appointment, nor did she bother cancelling same.

So, as you can clearly see, many of these alcoholics must "project" their inadequacy and frustrations into obvious hostility, criticizing such noble organizations as the Baltimore Area Council on Alcoholism, Alcoholics Anonymous, and hospitals and physicians as a group. It is hard enough to keep up with the demands of daily medical practice and tightly scheduled office hours. Therefore, it is understandable that many people in the medical and hospital field become quite perturbed by the difficulty

in handling and satisfying alcoholics, their demands and whims. As a whole, however, both the medical profession and the hospital administrators are progressively developing a more patient and more generous attitude towards the alcoholic, and we certainly don't wish to stereotype them, rather take them each as individuals on their own merits. Unfortunately, no hospital and no physician is ubiquitous enough to satisfy every patient, or to cure every illness, and we are far from perfect in being able to cope with every alcoholic.

If the complainant alcoholic felt frustrated in her inability to easily secure private medical help, the frustration is multiplied for those few members of the profession who have been entrusted by the Medical and Chirurgical Faculty to implement the AMA policy that alcoholism is a disease. For the past two years, free lectures to the medical and house staffs of all Baltimore area hospitals have been offered repeatedly in letters and flyers to the directors of medical education and the chiefs of the medical staffs. During Alcoholism Week, early in December, an afternoon was devoted to a professional seminar on alcoholism at the Eastern Health District. Two physicians showed up. The offer by the volunteer faculty of the Subcommittee on Alcoholism has been ignored, with the exception of a small gathering recently by the house staff of one of the smallest hospitals. In reality many more of us in the medical fraternity could inform ourselves on the more recent trends in recognition and treatment of the alcoholic. Numerous publications, a few good films, and above all the volunteer faculty for lectures are available through the Subcommittee on Alcoholism.

Elsewhere in this issue is an account of the highly successful cooperation of the City Health Department Alcoholism Clinic with a Baltimore general hospital.

Diagnosing and treating the alcoholic is only one of many unpleasant situations the practicing physician must face. The total inability and virtual prohibition to help the narcotic addict in private practice is an experience which most of us have frustratingly suffered. The papers relating to narcotic addiction in this issue make interesting reading. A slim ray of hope can be gained from the recent ambulatory treatment in connection with first offenders and the Probation Department of the courts.

The battered child has come into focus with increasing frequency, and it is hoped that discovery of this disheartening problem will become more obvious as physicians become increasingly alert to its existence.

Many of us have been placed in the unpleasant position of having to deny a patient the certificate of physical fitness to drive. Often patients and their relatives will attempt to outmaneuver the physician and will squeeze out some concession in order to retain the driving privilege. With the ever-mounting carnage on our roads, it becomes a matter of conscience for the physician to be sure that he is not the instrument which allows the truly disabled, incompetent, mentally and emotionally deranged person to add to the existing highway hazards to life and limb.

In most instances the disabled or incompetent or drunk driver is cited and subject to scrutiny only after he has had a traffic violation, which may already have caused bodily injury or death. Only when a person states on his renewal application that he has a mental or physical disability —and many do not—or when the Department of Motor Vehicles is tipped off by letter or telephone call that a particular driver has a disability, is such a person required to appear before the Medical Advisory Board.

The symposium by the Traffic Safety Committee adds to our knowledge of driving fitness. Since it is highly unpleasant for the practicing physician to personally have to deny a patient of long standing or a member of a valued patient family the right to operate a motor vehicle, it might be a distinct relief if a law were passed compelling the physician to report physical or mental disability to the Commissioner of Motor Vehicles for scrutiny by an impersonal committee of professional experts. This would be ideal but would meet with opposition on the part of the medical profession. It might be helpful, too, if agencies such as mental institutions, hospitals, heart evaluation centers, and neurology and eye clinics would exercise their powers by automatically reporting patients using their services. This special issue on the mores of medical practice, reminding us of the unpleasant problems we encounter in the daily practice of medicine, may be depressing. Hopefully, these papers will help us to meet these problems with more knowledge, a kinder attitude, and better patient understanding.

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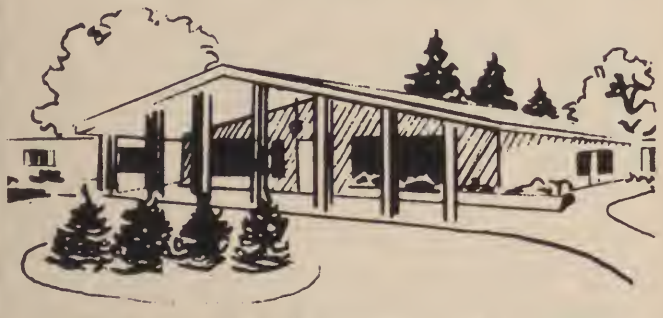


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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et ol.: Med. Times, 87:818, 1959.

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Baltimore's Alcoholism Clinic, now more than two years old, offers many services to help the physician in treating his alcoholic patients.

THE ALCOHOLISM CLINIC IN THE OVERALL TREATMENT OF THE ALCOHOLIC PATIENT

A. M. SCHNEIDMUHL, MD, MPH
Director, Alcoholism Clinic
Baltimore City Health Department

In September, 1963, Baltimore's first full-time Alcoholism Clinic opened at the Eastern Health District Building, 620 North Caroline Street. Within the framework of the Baltimore City Health Department, the new clinic gained the endorsement of the Medical and Chirurgical Faculty of Maryland, The Johns Hopkins School of Hygiene and Public Health, the State Departments of Mental Hygiene and of Health, and the Baltimore Area Council on Alcoholism. It also had established a mutual assistance program with Church Home and Hospital.

The clinic is now more than two years old, and it seems appropriate to report on its progress and again to offer its active cooperation to Baltimore physicians engaged in treating alcoholic patients.

First, a brief statement on the clinic staff and program. The full time staff consists of two psychiatric social workers, a clinical psychologist, an alcoholism counselor, and a secretary; working part time are a medical resident, an office clerk, and a number of dedicated volunteers. A Community Advisory Board, composed of leading citizens and representatives of the city's major official agencies, is regularly apprised of the clinic's activities. The board provides valuable assistance and general direction to the clinic's program.

The clinic is open to all residents of Baltimore City seeking help for drinking problems, either independently or as referred by physicians, employers, social agencies, clergymen, courts, and other interested parties. Services include physical, psychological, and social evaluations, individual and group psychotherapy, marriage counseling, chemotherapy, occupational therapy, nutritional consultation, and exposure to Alcoholics Anonymous. These services are offered as dictated by the particular needs of each patient. Whenever

possible, the patient's family—at least the spouse and teen-age children—share in the treatment program.

The clinic's philosophy, emphasized in all our contacts with and about patients, is that the alcoholic is a sick person, deserving of respect and consideration as a worthwhile human being, requiring special treatment but no special privileges.

During 1964, the average monthly intake was 11-12 patients (not including members of the patient's family). During the first eight months of 1965, the number had more than doubled (25-26 new admissions per month). Of the 206 new patients admitted January 1-August 31, 1965, the ratio of men to women was 3.5 to 1; 125 were between the ages of 31-50; more than half were married; and more than half of the women patients were housewives. Occupationally, the patients ranged from unemployed through blue-collar and white-collar workers to professional people.

Only about one-fourth to one-third of our patients seem to benefit from the clinic services. The others appear to lack motivation for treatment, either by prematurely terminating contacts with the clinic or by irregular clinic attendance, or by repeated relapses. We are trying to better understand this situation and to deal with it appropriately.

A. A high drop-out rate is expensive, both in terms of the apparent loss of the original investment (medical and psychosocial workups) if the patient does not return for treatment and in terms of the human suffering experienced by the patient and his immediate environment. Through the intervention of the family physician, the referring agency, or through home visits by the public health nurse, we made every effort to motivate the patient to return to the clinic.

B. A follow-up study of all patients admitted between September, 1963, and March, 1965, is being made in cooperation with The Johns Hopkins School of Hygiene and Public Health and the Instructive Visiting Nurses Association. We hope this will shed some light on why patients drop out of treatment and, whenever feasible, appropriate steps will be taken to remedy the situation.

C. Patient drop-outs and relapses generally do not contribute to the staff's high morale and enthusiasm so necessary in the treatment of alcoholic patients. The chronicity of alcoholism and the lack of family and community acceptance of alcoholism as a treatable disease are only some of the known factors responsible for the drop-outs. In treating alcoholism, one must remember that alcoholics are numerous and varied, that different treatment techniques are necessary for a successful therapeutic program, and that there may be treatment approaches that have not yet been explored.

A thorough understanding of these factors, as well as regular reviews of current literature, case conferences with people prominent in internal medicine, psychiatry, psychology, and social work (serving as consultants), regularly scheduled staff meetings to discuss the treatment and progress of individual patients, proper selection of patients for appropriate treatment programs, active participation in community planning, and education in alcoholism are some of the staff morale builders which, unfortunately, are often neglected because of lack of time.

Cooperation between the clinic and the practicing physician is most important. In all of 1964, only seven patients were referred to the clinic by physicians (including psychiatrists); in the first eight months of 1965, 21 patients were referred by physicians. Referrals from general, veterans administration, and state hospitals also rose sharply over the same period: from 35 in 1964 to 58 during the next eight months. A review of the sources of referral shows that only 15-20 physicians are making use of the clinic services.

The practicing physician is, and must always be, the primary treatment resource for the alcoholic, as for all other sick people. Referrals to a specialized clinic or to a hospital are usually made by the practicing physician as part of an overall treatment program, depending on the needs of the patient.

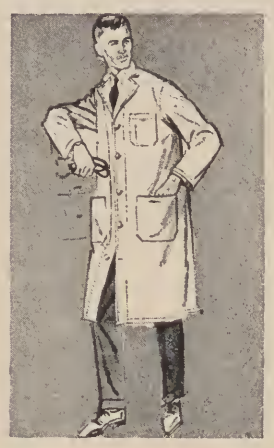
At what point might the physician refer an alcoholic patient to the Alcoholism Clinic? It might be when he begins to see an unhealthy increase in tension within or around the alcoholic and his family. It might be when he recognizes that his alcoholic patient needs more specialized or more comprehensive treatment or more time than he can provide.

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clinic. Indeed, the clinic's role is one of supplementing the physician's services. It makes every effort to maintain and strengthen the relationship between the patient and his physician. The clinic depends on the physician to do the necessary examinations, to treat any existing organic conditions, to arrange for hospitalization if indicated, and to follow up the patient when he no longer needs the special services of the Alcoholism Clinic. The clinic staff informs the physician of his patient's progress. If the patient drops out of treatment prematurely, the staff consults with the physician about possible means of re-engaging his patient in a treatment program, perhaps through the physician's contact with the patient and his family or through a home visit by a public health nurse or a member of the clinic staff.

In addition to providing direct services to the alcoholic patients referred by the practicing physician, the clinic staff is available for consultation on patients whom the physician continues to treat—on choice of one of the newer medications, for example, or on the choice of an inpatient facility for a patient.

All practicing physicians, and especially those in Baltimore City, are invited to regard the Alcoholism Clinic as a specialized medical facility designed to help them reclaim and rehabilitate the victims of alcoholism.

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Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The idea of Doctor's Day originated in Georgia in 1933 and was adopted by the Woman's Auxiliary to the American Medical Association in 1934. Since the analogy of the carnation is closely intertwined with medical science, the red carnation was chosen in 1949 as the symbol of Doctor's Day.

March 30, the official date, commemorates one of the greatest discoveries for the alleviation of pain and suffering. On March 30, 1842, Dr. Crawford W. Long first used ether anesthesia in surgery.

In recognition of the doctors' contributions to the people and communities they serve, the Woman's Auxiliary to the Baltimore City Medical Society, in cooperation with the Baltimore City Public Schools and the local hospitals, hopefully plans to sponsor a Doctor's Day art contest with the emphasis on creating a happy atmosphere for patients of all ages.

Also in honor of Doctor's Day, a contribution will be made by our auxiliary to the American Medical Association Education and Research Foundation, to be divided equally between The Johns Hopkins and The University of Maryland schools of medicine.

Mrs. H. Leonard Warres, *President*
Woman's Auxiliary to the Baltimore City Medical Society

Mrs. Stuart D. P. Sunday, *Chairman*
Doctor's Day

THE GENERAL HOSPITAL'S ROLE IN SERVICES TO ALCOHOLIC PATIENTS

JOSEPH D'ANTONIO, MD
Chief, Department of Medicine
Church Home and Hospital

For slightly more than two years, Church Home and Hospital has had a collaborative relationship with the Alcoholism Clinic of the Baltimore City Health Department. Some observations on our experience during this period may help to open more general hospital doors to acutely intoxicated patients.

Between April 1, 1964, and March 31, 1965, Church Home and Hospital admitted as inpatients 22 alcoholics referred by A. M. Schneidmuhl, MD, director of the Alcoholism Clinic, and 32 alcoholics referred through other channels. In our experience, the acutely intoxicated patient who is adequately treated causes no special difficulty either to the attending physician or to the nursing personnel.

Through regular consultations with Dr. Schneidmuhl, the medical and nursing staffs at Church Home and Hospital have developed a basic philosophy and an effective treatment program for both the emergency room and in-hospital patients. The philosophy, emphasized throughout our contacts with and about alcoholic patients, is that the alcoholic is a sick person in need of medical treatment, deserving of respect and consideration as a worthwhile human being, requiring specialized treatment but no special privileges.

In brief, the therapeutic milieu, accurate diagnosis, and treatment of the surgical and medical problems (skull fractures, subdural or subarachnoid hemorrhage, cardiovascular accident, uremic, diabetic, or insulin coma, gastritis, hepatitis) which may accompany or complicate the acute phase of alcoholism, judicious and adequate use of tranquilizers (chlordiazepoxide, thioridazine, hydroxyzine, promazine) to combat psychomotor agitation and insomnia, correction of the existing physiologic abnormalities resulting from prolonged drinking (fluid and electrolyte imbalance, vitamin depletion), and adequate diet are the cornerstones of the treatment program.

Church Home and Hospital has worked closely with the Alcoholism Clinic in treating the acute phase of alcoholism and complications of alcoholism. This hospital's experience suggests that the general hospital has a significant contribution to make in the treatment of alcoholism.

Certainly the general hospital is inappropriate for long-term treatment of chronic alcoholism, but during the acute stage of alcoholism, the general hospital staff can help significantly in motivating the alcoholic to seek specialized help once he is detoxified and well enough to leave the hospital. At Church Home and Hospital, the alcoholic patients are seen in consultation by Dr. Schneidmuhl, and they are encouraged to apply to the Alcoholism Clinic for continuation of therapy.

Not all alcoholics in need of hospital care are acutely intoxicated; some are admitted for treatment of complications resulting from prolonged, excessive use of alcohol. With these patients, the hospital staff can make a greater contribution if, in addition to treating the specific complications, they show concern for the basic condition, namely, the heavy, uncontrolled drinking, and tell the patient about the specialized treatment program offered at the Alcoholism Clinic.

No one treatment resource can meet all the therapeutic needs of alcoholics. In the broad continuum of services needed for this population, the general hospital, along with the practicing physicians, the Alcoholism Clinic, and the alcoholic rehabilitation units of the state hospitals, can and should play an important and useful role.

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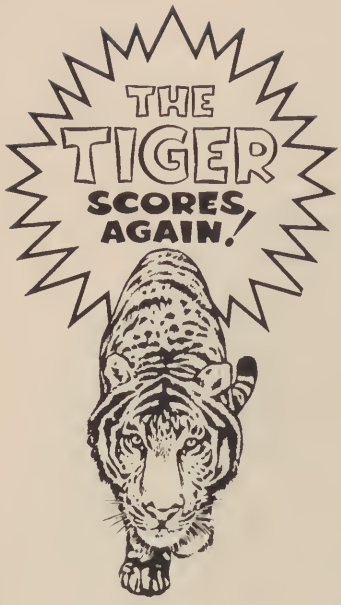
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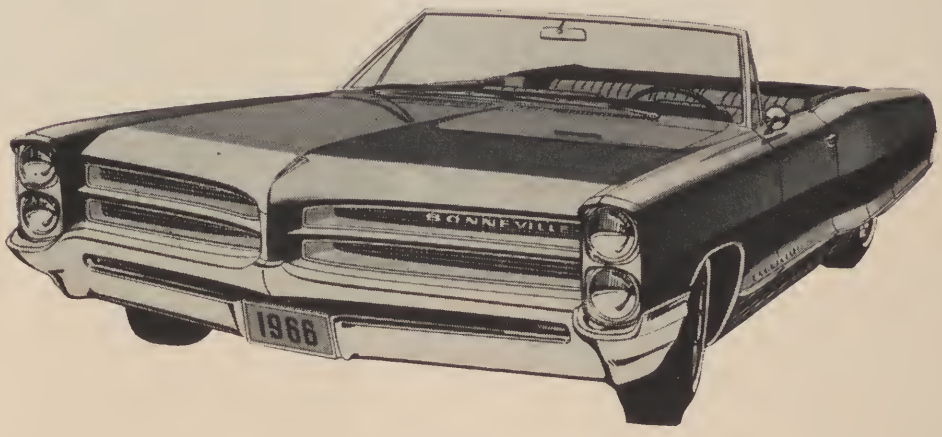
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THE NARCOTIC ADDICT

Some Reflections on Treatment

ALBERT A. KURLAND, MD
Director of Research, Department of Mental Hygiene

Narcotic addiction is a chronic disorder for which no effective treatment is known. Therapeutic efforts are confined to treating withdrawal reactions and trying to strengthen the personality structure of the addict. Many approaches are used, but their ultimate merit is questionable. The Research Department of the State Department of Mental Hygiene is investigating the deterrent effects of daily laboratory testing for opiates among patients closely supervised by a parole officer and receiving group psychotherapy.

This research is being supported by Grant MH-07616 from the National Institute of Mental Health, USPHS, Department of Health, Education and Welfare, and administered by Friends of Psychiatric Research, Inc.

The general practitioner is limited in treating the narcotic addict because of the legal problems involved, the difficulties of attempting to treat a withdrawal reaction outside of a closely supervised institutional setting, the problems in providing psychotherapeutic assistance over any extended period, and the complexity of social and supervisory resources necessary in the overall management. Consequently, his participation has mostly been focused on the diagnosis of narcotic usage, the treatment of one of its main complications, overdosage, and the providing of information and counsel relating to therapeutic resources available for the referral of such patients for treatment.

The physician who would attempt to treat the narcotic addict must, for all practical purposes, orient his approaches from a standpoint of a disorder which will require long-term management. The chronic nature of this disorder must not be lost sight of: otherwise, with the addict's propensity for having periods of exacerbations, there results an increasing feeling of frustration precipitating a sense of defeat and leading to a withdrawal by the therapist. This pessimistic outlook is verified by a number of reliable European and American studies, which report at least a 95% rate of recidivism during a five-year follow-up period.[1] Therapeutic experience with even well motivated, intelligent, and economically sound drug addicts has indicated a relapse after a five-year follow-up in most cases.[2] Many simi-

lar experiences have been reported by other highly capable clinicians concerned with the treatment of the narcotic addict.[3]

As the addict ages, his subsequent course often becomes obscured. Several reasons have been given for this. Among those suggested has been the development of more effective control in responding to the craving for narcotics, with the obvious implications. On the other hand, there are indications that the life expectancy of the narcotic addict may be lower because of death from accidental overdosage of illegally prepared narcotic preparations or from the complications resulting from the use of other drugs such as barbiturates, amphetamines, and alcohol.

The mechanism of the addition process is complex, involving physiologic, biochemical, and psychological parameters which are poorly understood. This is reflected in the attempts to quantify the process into habituation, physical and psychic dependence, and drug abuse. To explain these phenomena, a variety of models have been used. These have been described as cellular, neurophysiological, personality, psychoanalytic, conditioning, sociological, law enforcement, iatrogenic, and pharmacodynamic.[4] None of these, however, has been particularly rewarding in yielding suggestions for more effective therapy.

In view of this rather gloomy perspective, the therapeutic strategy in dealing with the vicissitudes of this disorder is perhaps best approached by focusing initially on the patient who has decided to make an attempt to "kick the habit." The factors which frequently bring about this decision in the narcotic addict are the development of a crisis in obtaining drugs, apprehension by a law enforcement agency, or mounting pressure from within the addict. The initiation of this step mobilizes a great deal of anxiety which frequently intensifies to the point of panic and precipitates a flight to a hospital.

Medical management of the acute withdrawal reaction is relatively simple and can be accomplished in a week or two. Most authorities on treating the narcotic addict agree on the importance of treating the withdrawal reaction in a properly equipped institutional setting because of the need for a high degree of supervision due to the manipulative behavior of this type of patient. With the subsidence of the withdrawal reaction, the voluntary addict soon demands to be discharged, providing little opportunity for making any additional plans.

If the addict does agree to participate in a treatment program, it should always be with the realization that intermittent deviations from abstinence are inevitable. At times these may progress to the point of re-addiction, necessitating another period of hospitalization for treatment of a withdrawal reaction. There is some evidence that consistently maintained help diminishes the number and periods of decompensation. This support maintained over a number of years may prevent the addict from compounding his delinquencies, which in turn lead to increasing punitive actions on the part of society with accumulating penalizations and a waste of the individual's life.

A program of sustained support is complex, requiring long-term supervision of the narcotic addict in the community. In our experience, prolonged hospitalization in a state hospital seems unwarranted in view of the poor therapeutic results.[5] Frequently, this type of hospitalization arouses increasing antagonism in the narcotic addict. This negative attitude may result either from his unrealistic expectations as to what treatment he will receive from the hospital or from the hospital's inability to provide any specific treatment other than custodial care. Furthermore, the narcotic addict finds it difficult to conceive of his being sick, in terms of the usual psychiatric disorders, although the use of special environmental settings, such as halfway houses and synanon settlements identified with the treatment of the narcotic addict, are readily accepted. Whatever use he may make of these facilities, he must ultimately return to his own environment and carry on as best he can.

Experimental approaches carried out by the research staff of the Department of Mental Hygiene led to the establishment of an outpatient clinic which provides psychiatric help for the narcotic addict after working hours in order to minimize conflict with his job. This program is geared to a high level of supervision employing laboratory control (daily urine analysis utilizing thin layer chromatography for the detection of opiates); supervision by a parole officer; and weekly attendance at the clinic for group psychotherapy and individual counseling.

The participation of the addict and the mainte-

nance of this control necessitates that the addict be either under court order or on parole from a correctional institution. Without this type of control, the attempt to obtain the narcotic addict's cooperation has proved ineffective. The present approach provides for a degree of monitoring to detect trends toward increasing breeches of abstinence with an opportunity to intensify the therapeutic management at critical periods.

Should this method of control fail, the addict can be returned to a correctional institution without loss of his opportunities for parole. At the same time, he has been helped to some extent from compounding his possible delinquencies before he finds himself overwhelmed by a full blown relapse. Under these circumstances, he may have a chance for another trial on the program. With the possibility of arresting or interrupting the trend toward readdiction, the hope is that there may be an increasing attenuation of the need for drugs after reinstitutionalization with a subsequent opportunity to return to this clinic at a not too distant date.

As the addict cycles through these periods of abstinence and deviation, he may ultimately be much more effective in helping himself achieve a greater degree of rehabilitation. It is still too early to predict the success of this approach, for this will require several years of observation. It is anticipated, however, that maintenance in this type of an ongoing program, based on sympathetic and humane considerations, may ultimately yield the reward of a gradually maturing individual who no longer has to flee from himself or the demands of society via a narcotic exit.

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Why is the incidence of drug addiction 100 times greater among physicians than among the general population?

DRUG ADDICTION

A Medical Hazard

JOHN C. KRANTZ, JR., PhD
Professor Emeritus of Pharmacology
University of Maryland School of Medicine;
Director of Scope, United States Pharmacopeia

Drug addiction is approximately 100 times greater among physicians than among the general population. This represents a waste of many valuable years of training and an extravagant use of funds for medical care. But what is most tragic is that society loses a doctor and acquires a patient that seldom can be cured. Drug addiction in a doctor is like the serpent in Eden; it will ultimately drive him out of the garden of his profession.

The principal drugs that evoke addiction are the derivatives of opium and certain synthetic chemical compounds which elicit pharmacologic effects similar to the alkaloids of opium. In many areas of the Orient smoking opium is a common custom involving a considerable segment of the population. In many of these areas, population pressures are so great that famine and pestilence are rampant. Hard labor with primitive tools exacts its devastation in misery and illness. Here opium often provides a surcease from the almost intolerable existence of the teeming, ignorant millions, and its effects are not so catastrophic. But such escape from reality has no place in Western civilization. In our culture these drugs have one purpose: to obtund intractable pain.

The pharmacologic basis for drug addition is complex and puzzling. Certain narcotic drugs, such as alcohol, produce tolerance and habituation, and in many people this is a grave malady. Yet the chronic alcoholic, if he has the will to abstain from all alcoholic beverages, can overcome the disease.

Withdrawal symptoms of alcohol are not serious; they are mainly psychic. The body does not acquire physical dependence on the presence of alcohol in the tissues. Morphine presents a different pattern of addiction. As with alcohol, the individual shows tolerance and habituation, but further, he develops a definite physical dependence upon the drug. Sometimes the withdrawal symptoms of morphine addiction are mainly psychic, but after long repeated use of the drug, physical dependence develops. The withdrawal of morphine after addiction produces devastating

symptoms which are ameliorated by a return to the drug.

True addiction is produced by opiates and certain synthetic narcotics. It has been defined as *that condition of mind or body induced by drugging which requires a continuation of that drug, and without which serious physical and/or mental derangement results.*

The World Health Organization (WHO) gives the following definition of drug addiction:

> Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: 1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; 2) a tendency to increase the dose; 3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug.

In the United States about 80% of drug addicts are men and 56% are Negroes. Many addicts have criminal records. Furthermore, this problem is associated with life in congested urban centers. Of the approximately 50,000 addicts in the United States, 44% are in New York, 14% in Illinois, and 13% in California, and the addiction is concentrated in the large cities. Nevertheless, addiction may occur in any environment and in any stratum of life.

The number of people who become addicted from using narcotics prescribed by physicians for the relief of severe pain is comparatively small. The percentage of accidentally addicted estimated by Rayport (1954) was about 14% in more than 1000 cases. This suggests that the basic psychic pattern of the person plays a dominant role in addiction liability.

Approximately one-third of the addicts owe their addiction, in part at least, to overindulgence in alcohol. The same basic personality defect which leads to use of alcohol as an escape from reality is likely also to be responsible for their taking recourse to narcotic drugs.

Since about three-fourths of the addicts are first criminals, it appears that we are dealing with persons with a definite psychopathic diathesis. These are people who have misinterpreted their own environmental settings and their place in the social order and have attempted to mask the impact of reality by the effect of narcotic drugs.

In 1961 the estimated number of narcotic addicts in the United States was 45,000-50,000, an incidence of about one in 3,500 of the population. Estimates reflect that 92% used heroin, 3% used morphine, and most of the others used synthetic drugs, opium, paregoric, or codeine.

Addiction is not always easy to diagnose. Many addicts carry on their normal activities without physical or mental signs of their drug addiction. The pinpoint constriction of the pupil is usually a faithful criterion, although it fails in some addicts. As a rule the addict suffers with chronic constipation, interrupted intermittently by intestinal cramps and diarrhea. Injection depots may be visible on the body. These may have become infected, and abscess formation may be present. They usually appear in areas especially accessible to the individual with his needle and syringe.

Many personality changes take place in the drug addict. Outstanding is the tendency to become esoteric and introspective. He frequently shuns social contacts which formerly engaged his attention. Moral barriers seem to disintegrate. The clandestine, furtive manner through which he secures illegal narcotics appears to invade other segments of his life. Frequently leading questions which he poses regarding drug storage and supervision are diagnostic of his thought patterns concerning the acquisition of narcotics.

Injection of morphine into the addict does not bring the usual response of depression, sedation, and narcosis. He is generally a mendacious individual. Therefore, despite his history and possible physical signs, the most reliable diagnosis for addiction is the appearance of the withdrawal syndrome upon complete and enforced abstinence. The withdrawal syndrome may be induced precipitously upon the injection of nalorphine.

Since doctors are human beings, it is easily understood that a comparable proportion of them might become addicts. On the other hand, it might be argued that owing to the physician's superior training and social dominance in the community, the percentage of addicts in the medical profession would be less than that in the general population. Unfortunately neither of these two conditions prevails. Why is it, then, that the incidence of addiction in the medical profession is 100 fold greater than among the general population?

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First, the degree in medicine and the license to practice have not changed the physician's status as a person. He is still subject to all of the temptations and moral ineptitudes that beset other people. Opiates, unlike the law of the land, do not recognize the MD degree. The millions of cells in the brains of physicians succumb as readily to the biochemical lesion of drug addiction as do those of non-physicians. Knowledge of drug addiction—and unfortunately many physicians possess only a smattering of this—is no protection against its ravages. The lesion is biochemical.

The second factor is the nature of the life the doctor must lead. There are comparatively few men in any society upon whom the mantle of Hippocrates falls. These are dedicated men. There is an emotional drain on the life of the doctor. The doctor needs relaxation and rest to protect his emotional life from the trauma of repetitious pain, death, and sorrow. Too often alcohol and barbiturates are used instead of a well-deserved and desperately needed vacation. Too often the doctor fails to heed the advice he gives to his patients, again forgetting that even though he is a doctor he remains a person.

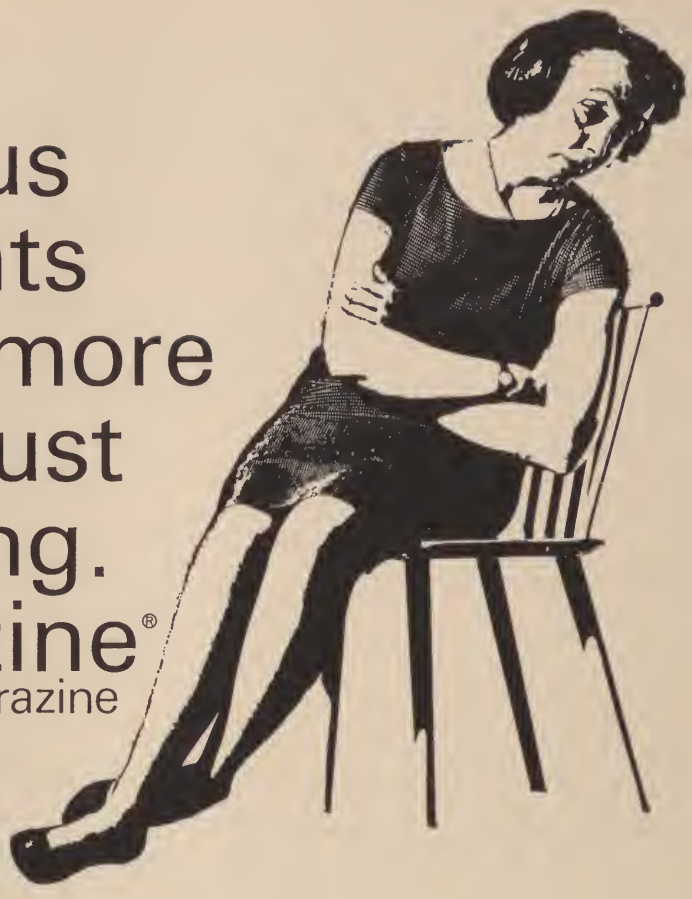
The third reason for addiction among doctors lies in the driving forces of propinquity and availability. To obtain narcotics he does not need to rob a doctor of his bag, he has one at his bedside. After a devastatingly hard day, absorbing the shocks of the tumultuous sea of other peoples' troubles, if insomnia persists in spite of alcohol and barbiturates, the syringe with the narcotic is within arm's reach. And with it, he knows, fatigue will vanish, epigastric gnawing will be quelled, dizziness will be dispelled, and Morpheus will receive him with open arms. Once the Rubicon is crossed, the barriers are let down one by one, and the doctor is started on a broad highway to certain destruction. The escape from the impact of reality constantly haunts him as he continues at a devastating pace in chasing windmills. He can never forget the honeymoon of his addiction. The only sure cure for drug addiction is never to let it happen.

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THE ABUSED CHILD

KARL M. GREEN, MD

Citizens of the United States have been hearing and reading about the legislation involving the Battered Child Syndrome. Editorials, national conferences, and a series of four TV programs on the Huntley-Brinkley Report, in October, 1965, have discussed the moral, legal, and medical responsibilities of child abuse.

First reports of the correlation of roentgen manifestations of unrecognized fractures appeared in medical literature in 1953. Since then numerous articles have appeared with recent stress of good legislative laws and methods for determining the best management medically and legally. The magnitude of this problem probably never will be fully determined. Children under three years, especially those under one year, are most frequently involved. Forms of abuse may be physical, nutritional, and mental. Caffey, in 1946, reported the association of subdural hematoma and multiple fractures with trauma. Silverman described the association of these bone lesions to unrecognized trauma and a hospital survey by Kempe revealed that the number of cases was much higher than expected.

Five years ago only one state had a law requiring the reporting of physical abuse of children. Recently the Childrens Bureau of the Department of Health, Education and Welfare announced that 46 states now have such statutes. The exceptions, according to the bureau, are Alabama, Hawaii, Mississippi, Virginia, and the District of Columbia.

Child abuse is said to cause more deaths than auto accidents and such diseases as leukemia, cystic fibrosis, and muscular dystrophy. The incidence is estimated from 750 to 10,000 cases per year. New York State in the first eight and one half months of the law had 231 cases re-





This set of x-rays on one patient reveals multiple fractures in different stages of healing with long bone periosteal proliferation.

(X-rays courtesy of James Lyons, MD, University Hospital, Baltimore)

ported by medical sources. Child abuse occurs not only in the slums but also among professional families and those in the country club circles.

This entity has been well defined in other publications. The purpose of this paper is to re-emphasize the necessity of alerting the medical community to the problem. It certainly is one of the unpleasant aspects of medical practice.

Clinically the abused child may appear to have a history of a short illness before examination with gross discrepancy in the physical examination findings of malnutrition, anemia, and possibly fractures. The less obvious cases and the frequent changes of the source of medical attention make detection even more difficult. The highest incidence occurs in children too young to give a history. Trauma attributed to another sibling, hot liquid, accidental poisoning, accident proneness, unexplained convulsions, anemia, hematuria, and bruises may be the presenting symptoms.

A radiologist was the first to describe this entity, and radiologists often are the first to suspect it in a patient. The x-ray findings are characterized by long bone periosteal proliferation, metaphyseal corner fractures, epiphyseal injuries, and multiple fractures in different stages of healing.

After a single episode of trauma, the x-ray finding may reveal local soft tissue swelling; therefore a repeat x-ray examination in 10 days may be indicated to look for soft callous formation.

The periosteum in the infant is not as tightly adhered, and evidently trivial trauma allows separation with subperiosteal bleeding with elevation. Then subperiosteal calcification (illustration) appears in 10-14 days as a homogenous layer of calcification surrounding the bone. It may be localized or involving the entire shaft with the appearance of squaring of the ends of the long bones. A skeletal survey is probably indicated in all children with subdural hematomas.

The importance of these tragedies is that they are not self limiting, and there are many facets. The trauma is repeated until the patient is removed or the environment is changed. If the family is responsive to help, the best place for the child is at home, since removal may be disastrous and not all institutions and foster homes are adequate. The problem is a social, medical, and legal one. The laws passed by states grant physicians immunity when reporting suspicious cases, but all too frequently the physician avoids penetrating questions which might bring forth the unpleasant truth that he would be obliged to follow up.

Social agencies are becoming more aggressive in attempting to locate and help the involved families. A good social worker is one of the physician's best assistants in these matters to investigate in order to assert the medical, legal, and social aspects. From the social worker's evaluation, she can petition the appropriate legal division on behalf of the child.

It is important that physicians recognize this problem and follow the current events. Public opinion has greatly increased with the resultant laws. Physicians can contribute a lot not only to the medical aspects but also the legal and social aspects. Research is being done to define methods of prevention and to find a more realistic solution for the child and his parents.

The problem of the abused child involves most specialties of medicine. Reporting cases is a clear duty, just as with a gunshot wound. This problem is a challenge to every physician who treats children.

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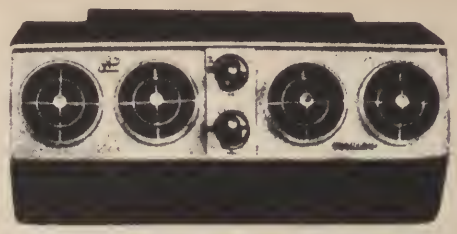


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DESOXYN® Gradumet® (methamphetamine hydrochloride)

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The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

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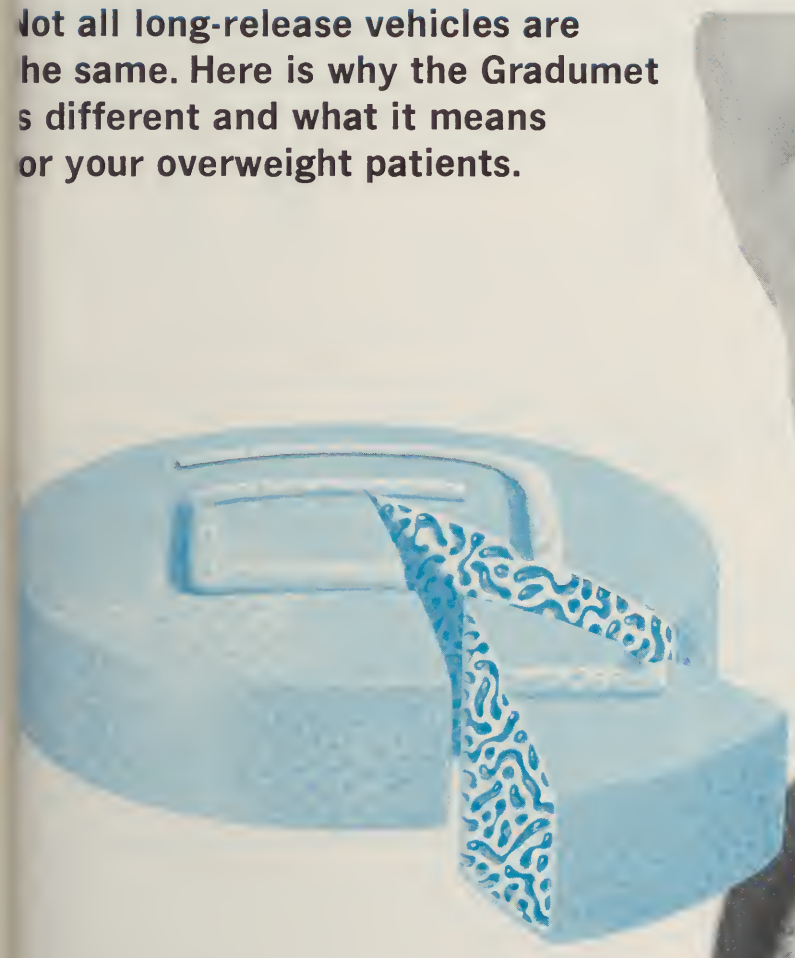
Both drugs are released in an effective dosage ratio throughout the day.

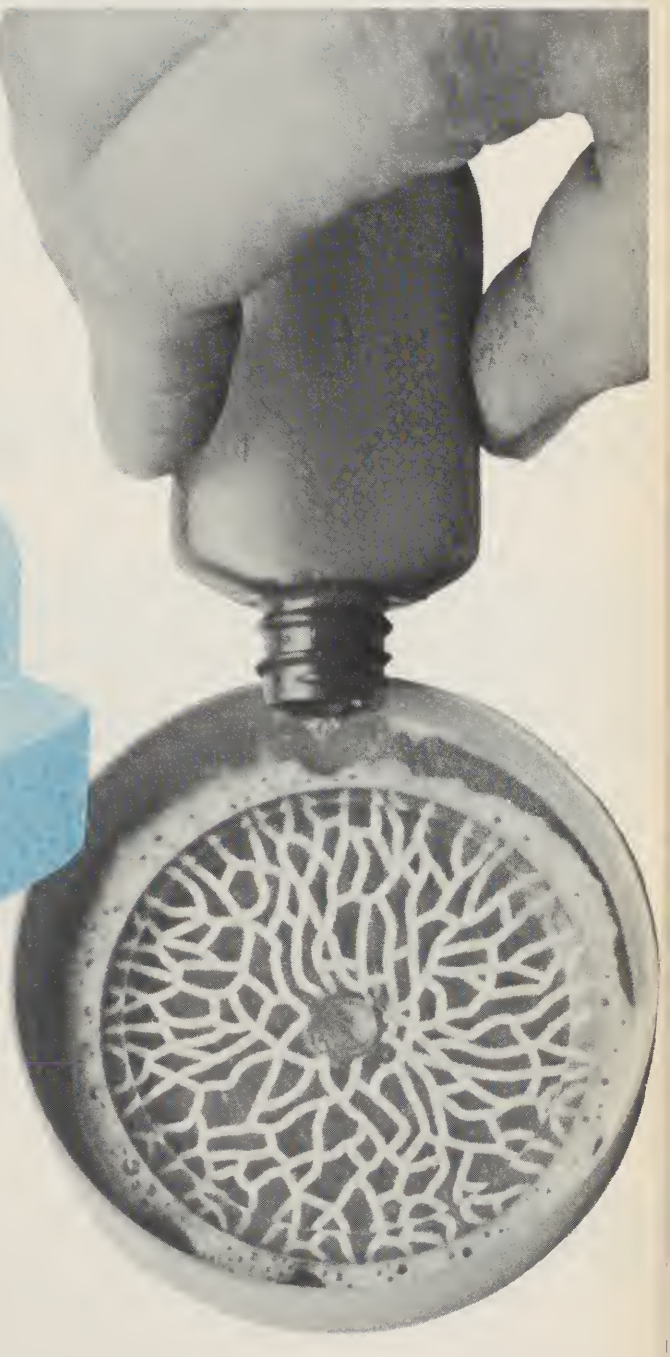


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DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

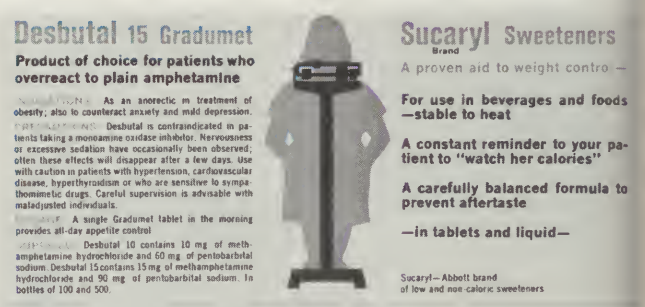


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PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
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A Symposium on MEDICAL CONDITIONS CONSTITUTING A HAZARD IN DRIVING

RUTH W. BALDWIN, MD L. R. SCHOOLMAN, MD PHILIP WHITTLESEY, MD H. F. KINNAMON, MD

A. N. DOUDOUMOPOULOS. MD BARBARA HULFISH, MD IRENE L. HITCHMAN, MD

In 1947, at the request of the late Dr. Howard Bubert and the Commissioner of Motor Vehicles, the State Legislature authorized appointment of a board of physicians to advise the Commissioner as to whether drivers or applicants for licenses known or reported to have a medical condition should be allowed to drive. In the first year 45 people were seen. The number of people referred to the Medical Advisory Board gradually increased, and between July 1, 1964, and June 30, 1965, 2,480 people were seen. The board has had to increase its membership from six to 21 this past year and the number of meetings from 13 the first year to 89 in the past year.

Drivers or applicants for driver's license may come to the attention of the Medical Advisory Board in one of three ways: 1) by stating on the application form or renewal form that he or she has a mental or physical condition which may affect driving, 2) by a report from a physician, neighbor, member of family, etc., that a person has a medical problem, and 3) by police, magistrates, judges, or license examiners or reviewers.

From July 1, 1962, through June 30, 1965, 7,276 people were seen. The board recommended that 5,410 be approved and 1,866 be disapproved. Few of the cases approved have been involved in any accident as a result of their medical condition.

The aim is not to prevent a person with a medical problem from driving but to try to assure that his condition is under the best control possible and that he is a better risk. Most of these people are seen again at three-month to yearly intervals. This motivates them to keep their health at the best possible level, as the loss of license is always a threat. Many drivers disapproved once may be approved in a later visit when their medical condition has improved.

Members of the board do not examine these people except to check muscle power, blood pressure, etc. when indicated. The Medical Advisory Board depends upon reports from physicians and hospitals and may ask for additional tests or examinations before making a recommendation.

Ruth W. Baldwin, MD

BLACKOUTS, FAINTING, FITS, SPASMS, EPILEPSY

These terms are usually used interchangeably by the laity. This condition, if not controlled, is always a severe risk, as a brief moment of unconsciousness or amnesia can cause an accident. Thus, this group is carefully evaluated.

In the three-year period, 1,435 people with this condition were seen, of whom 1,000 were approved and 435 disapproved. Histories of type of seizures, age of onset, frequency, physical and neurologic examinations, electroencephalograms, and other tests done are requested. The medication taken is also considered.

A patient usually is required to have two to three years without a seizure before it is recommended that he drive. Since it is impossible to say an individual having seizures only in sleep won't have one in the waking period, the same rule applies. Even though a patient may have a prolonged aura, it is still considered a hazard for him to drive, as it is difficult to predict when he will have a seizure without an aura or with an aura too short to be of any help to him. Patients having amnesia attacks such as psychomotor or temporal lobe epilepsy are of particular risk because they frequently may have no aura and may have these seizures at unexpected times. Usually if a patient goes two to three years free of seizures, the chances for a seizure to occur is slight.

Once he obtains his license, the patient is asked to report any change in medication or seizure which may occur. He is also seen at 6-12 month intervals and after three or four years may be placed on an affidavit.

Ruth W. Baldwin, MD

DIABETES

Diabetes is the referring cause of 25% of cases before the Medical Advisory Board. It is an important cause of auto accidents not only because of the vascular pathology of the retina, heart, and extremities but also because of the more common and dangerous hypoglycemia as a side effect of drug treatment.

An acute attack of hypoglycemia may produce diplopia, weakness, disorientation, syncope, convulsions, and coma. Any one of these effects can cause an accident. Hypoglycemia can be produced by the oral drugs, Orinase, Dymenlor, Diabenese, and DBI, as well as by injections of insulin. The juvenile diabetic is particularly prone to sharp drops in blood sugar, not only from the hypoglycemic effect of drugs but also from irregularity of food intake and violent exercise. Diabetics, especially the juvenile, must know what hypoglycemia is, how it may affect him, and how to treat it. We want to see each diabetic at least once to be certain that he understands hypoglycemia and its treatment, and we carefully instruct him always to carry sugar or candy in his car.

The visual complications of diabetes, retinitis, and early cataract may cause partial or complete loss of vision. These conditions do not come on acutely and are usually apparent to the person. We must be certain that the diminished visual acuity is not enough to threaten traffic safety. Ordinarily we do not test vision but rely on the written report of the physician. Should we detect grossly poor vision or have any doubt about the reported vision, we require a reexamination by a qualified ophthalmologist, meanwhile recommending suspension of the driver's license.

Hyperglycemia and ketoacidosis to the level of coma has not been a problem. This condition comes on gradually over a period of hours and usually makes the person too ill to take the wheel. Yet it may occur more acutely, particularly in a young diabetic ill from some bacterial or viral infection. All diabetics must be warned about the onset of drowsiness while driving as a possible precursor of coma.

Diabetes and its present drug treatment commonly produce hazards to traffic safety in the form of diminished vision and hypoglycemic episodes. It is important that every diabetic be examined by the Medical Advisory Board to check on these risks. To save the applicant unnecessary repeat visits, we urge the physician who receives one of our diabetic forms to carefully make and report the complete examination requested. In this way we will be helped to make the highways safer for all.

L. R. Schoolman, MD

CARDIAC DISABILITY

The effects of cardiac problems which may present a driving hazard are 1) alterations in judgment, 2) inadequate reaction time, 3) unconsciousness.

Cardiac difficulties which result in or produce cerebral anoxia, pain, or syncope are the sources of concern. In the past three years, 1,032 such cases have been seen by the Medical Advisory Board. In 783 a recommendation was made for continued driving; in 249, the recommendation was that driving not be continued, either temporarily or permanently. The recommendations were based on information provided by the patient in an interview with the board together with medical information provided by the physician.

The commonest problems have been:

1. Aortic stenosis, symptomatic
2. Stokes-Adams syncope

3. Heart block, complete or incomplete, variable or symptomatic
4. Myocardial infarction
5. Coronary insufficiency with angina
6. Aortic aneurysm, particularly thoracic, and symptomatic
7. Valvular disease resulting in cardiac surgery, especially those resulting in the use of prosthetic valves, with embolic potential
8. Cardiac arrhythmias resulting in implantation of pacemakers and paroxysmal arrhythmias capable of producing syncope of distraction
9. Chronic congestive heart failure with resulting cerebral edema and anoxia with resulting diminution in judgment and prolonged reaction time

ASCVD with symptoms of senility and delayed reaction is a problem frequently seen but not listed here under cardiac disturbances.

In order to advise the Commissioner whether the hazard is remote both for the patient and his fellow motorists, the Medical Advisory Board needs all appropriate factual, physical, historical, laboratory, and therapeutic data along with the physician's prognosis and recommendations for continued care. An interview with the patient helps the Board to assess the patient's functional capacity.

Often the patient does not take the medications which the physician has prescribed and fails to see his physician at the recommended intervals. The Board's request for current and continuing information from the patient's physician often provides more frequent follow-up by the physician and lessens the risk on the road. The subjectively tender question of when a person may safely drive without significant hazard to others after he has had a coronary occlusion and after cardiac surgery, for instance, places an unnecessary onus on the physician. The decision should be made by the Commissioner, based on appropriate information from the physician.

Medication poses a problem, particularly with respect to those possible effects in altering judgment or reaction time. On the other hand, the patient's own failure to take medication, either because he has been asymptomatic or because he has forgotten or for financial reasons, has often brought about the return of jeopardizing symptoms. Those conditions which remain stable for prolonged periods, particularly arrhythmias and valvular disease states, generally do not produce jeopardizing symptoms, and most patients are permitted to continue driving.

Philip Whittlesey, MD

ORTHOPEDIC PROBLEMS

Between July 15, 1962, and June 30, 1965, 1,449 patients with orthopedic problems were seen. Of this number, 1,363 had paralytic conditions and 86 were amputees. Paralytic conditions included polio, hemiplegia, spasticity, and traumatic paralysis. Amputees both with and without prostheses were considered. Of the paralytics, 1,157 were approved and 206 disapproved in recommendations to the Commissioner; of the amputees, 70 were approved and 16 disapproved.

Of each patient the Board considers, "Is this patient a safe driver to himself and to others?" If the verdict is that he is an unsafe driver, the Board considers whether special equipment be provided for the vehicle which help the patient to be a safe driver.

If the patient has a stable deformity or problem, usually one visit to the Board is sufficient. If the patient is making progress with treatment, he would be asked to return, especially if he is regarded as unsafe on first visit.

Howard F. Kinnamon, MD

MENTAL RETARDATION

Only three applicants with mental retardation were seen in the past three years; one was recommended for approval and two were not. Usually if the applicant can read or recognize signs, he is deemed able to drive unless his retardation is severe. In general, only those in the minimally retarded range are considered candidates for driving. If some other problem coexists, such as a behavior problem or another handicapping condition, then the risk increases and the advisability of allowing him to drive is lessened.

Ruth W. Baldwin, MD

PSYCHIATRIC DISORDERS

The emotionally well-adjusted driver is a safe driver. The emotionally disturbed driver is accident prone and can be a menace on the road. Driving is a full time job. In most accidents, the driver was preoccupied with matters other than

driving. Individuals who are under severe stress or are depressed or hallucinating should not drive. Unfortunately, the emotionally disturbed person either is unable to recognize that he cannot drive safely or refuses to accept the fact.

Between July 1, 1962, and June 30, 1965, 982 patients with some form of psychiatric disturbance were seen. Of these, 535 were recommended for approval and 447 were not.

A. N. Doudoumopoulos, MD

NEUROLOGICAL PROBLEMS

The most important consideration often turns out to be not the specific disability but how the patient handles it. Depression, irritability, intelligence, maturity, understanding of his illness, his attitude, mental alertness, and experience may mean far more than whether the patient can move only one finger or not. Also, whether the condition is changing or static is often more important than the condition itself. A patient who loses one eye secondary to trauma usually learns to accommodate to loss of depth perception in one and a half to two years, but if he has intermittent ptosis, he may be a hazard for much longer.

Only the exceptional patient can learn to drive for the first time after a sudden onset of neurologic deficit. Detailed tests for the integrity of the sensorium, particularly recent memory and ability to catch on to jokes is useful.

Corollary conditions which ordinarily would not concern one may be important, as in the person who gets arthritis in his left knee and has a mild Parkinson's disease affecting primarily the right side or the patient who gets hemianopsia but cannot turn his head to compensate because of cervical osteoarthritis.

A good criterion of mental ability is whether the patient is *mentally* capable of carrying on his old job(s) even if his limbs are impaired to the point that this is no longer practicable. If so, perhaps, hand controls or a "spinner" on his wheel or changing his dimmer switch to another site is all that is necessary.

Other considerations include how long the patient has been driving, how much driving he has done in the past three to five years as traffic conditions have become more complex, whether he has ever driven a cab, bus, or truck professionally and for how long and how long ago, where and what traffic conditions predominated, his accident record, and whether he had more frequent accidents (or close shaves) in the past year or two than previously.

It is wise to see neurological patients late in the day—even in the evening, if possible—as many conditions become worse later in the day. This is particularly true of myasthenia gravis. Many patients who have full recovery after a stroke or an exacerbation of multiple sclerosis begin to drag a leg again or become ataxic with a cold and unknowingly become hazardous.

In a teen-aged patient, his school grades and extracurricular activities may give a clue to his conscientiousness, his maturity, his judgment, and his tenacity.

Between July 1, 1962, through June 30, 1965, 578 people were seen with atrophic or degenerative neurological conditions, including multiple sclerosis, myasthenia gravis, Parkinson's disease, and Huntington's chorea. Of these, 356 were recommended for driving and 222 were rejected.

Barbara Hulfish, MD

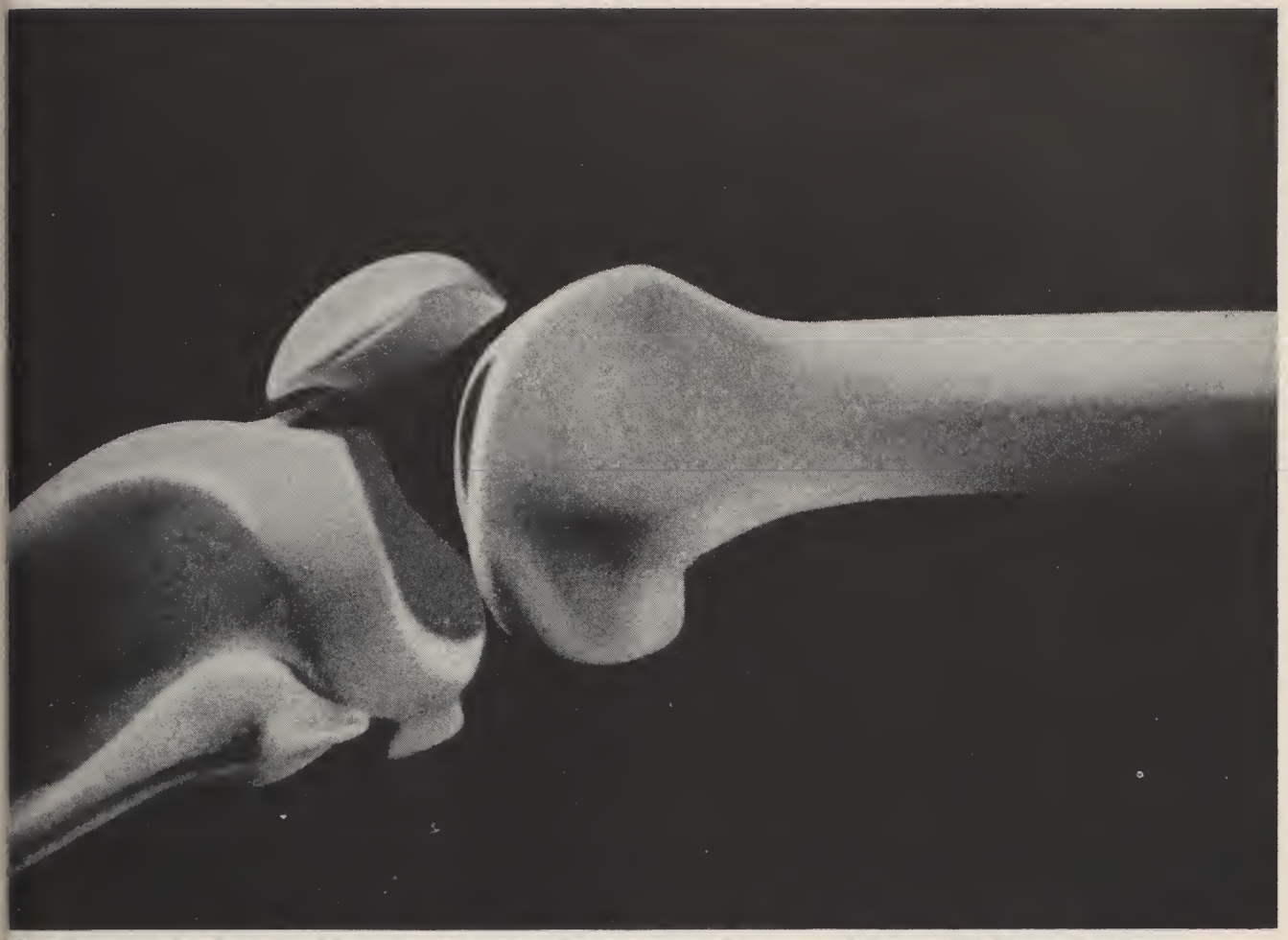
ALCOHOLISM

Of all the drivers referred to the Board during the past three years, 310 were alcoholics or problem drinkers. The Board recommended that 169 of these applicants be approved and 141 be disapproved. The ratio of approvals to disapprovals for all types of medical disability is about three to one. The high proportion of medical disapprovals for alcoholic drivers indicates the physicians' concern for the public safety.

The alcoholic referred to the Board is evaluated by means of a personal interview, a medical report from his family physician, or by hospital reports with the medical and social history. In a questionable case, a relative may be interviewed or a psychiatric examination may be requested before a recommendation is made to the Commissioner of Motor Vehicles.

An article on the alcoholic driver is being prepared for a future issue of the MARYLAND STATE MEDICAL JOURNAL.

Irene L. Hitchman, MD



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large number of investigators have reorted major improvement in about 75% of ases. Some patients have gone into remison. Relief of stiffness and pain may be fol-wed quickly by improved function and resution of other signs of inflammation. And utazolidin alka is well tolerated, especially nce it contains antacids and an antispasodic to minimize gastric upset.

ontraindications
dema, danger of cardiac decompensation; story or symptoms of peptic ulcer; renal, epatic or cardiac damage; history of drug llergy; history of blood dyscrasia. The drug ould not be given when the patient is se-le, or when other potent drugs are given oncurrently. Large doses are contraindiated in patients with glaucoma.

recautions
btain a detailed history and a complete hysical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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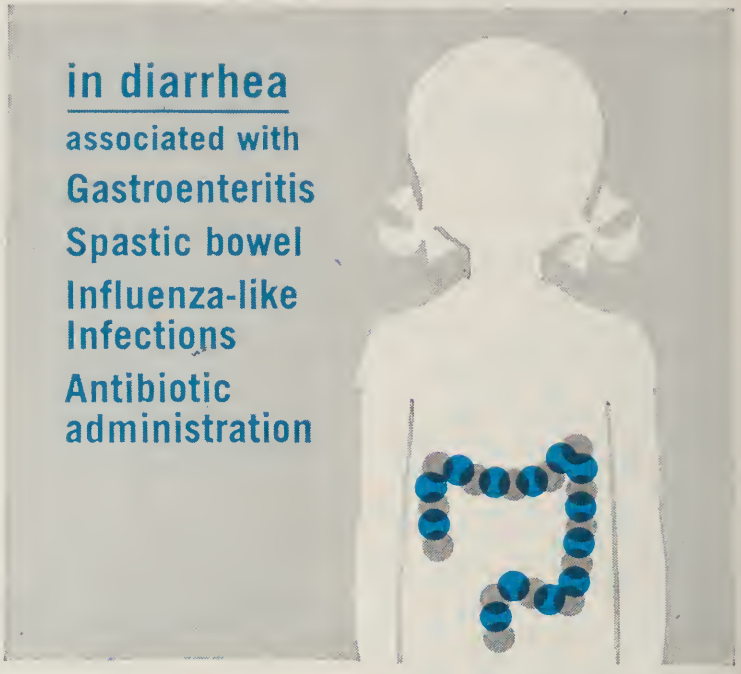
Addenda to Directory of Registered Physicians

PHYSICIANS REGISTERED NOVEMBER 1, 1965, TO FEBRUARY 1, 1966

Abrahams, Joseph, Esworthy Rd., Germantown, Md.
Acle, Eduardo R., 141 Hubbard La., Williamsburg, Va. 23185
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Acosta-Rua, Gaston J., 18110 Lorain Rd., Apt. 26, Cleveland, Ohio 44111
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Akopiantz, Levon A., 237 S. Old Manor Rd., Wichita, Kan. 67218
Amarillo, Rizalito A., 2075 Langhorne Rd., McCausland Ridge Apts., Lynchburg, Va. 24501
Amberson, Julius M., 428 Hamilton Ave., Silver Spring, Md. 20901
Anderson, Margaret L. M., 53 Franklin St., Annapolis, Md.
Andreu, Jose R., Rosewood State Hospital, Owings Mills, Md. 21117
Arner, Rodolfo A., 1231 Abercrombie Dr., Rome, Ga. 30161
Arrabal, Juan C., 1736 Edgewood Rd., Baltimore, Md. 21234
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Bergman, Roy Thomas, 2751A Augusta, Aberdeen Proving Grd., Md. 21005
Berman, Joseph I., 5952 E. Pratt St., Baltimore, Md. 21224
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Boolukos, Peter J., 406 Pinehurst Ave., Salisbury, Md. 21801
Boyd, Joyce M., 4719 Melbourne Rd., Baltimore, Md. 21229
Bryk, John P., 2205 Dulaney Valley Rd., Timonium, Md. 21093
Burns, Robert B. P., 2977 N. Providence Rd., Media, Pa. 19063
Calley, William D., 4000 N. Charles St., Baltimore, Md. 21218
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Dwork, Ralph E., 4204 Cotswold Dr., Harrisburg, Pa. 17110
Elton, Richard C., 1927 Rosemary Hills Dr., Apt. #3, Silver Spring, Md.
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Lidd, David, 5349 Pooks Hill Rd., Bethesda, Md. 20014
Lundie, William Mc., 2711 Kirkwood Pl., Hyattsville, Md.
McCune, William R., Showers Lane, Rt. #1, Martinsburg, W. Va. 25401
Macon, Edward M., 138 Church St., N.E., Vienna, Va. 22180
Magal, Ivan V., 6204 93rd Pl., Lanham, Md. 20801
Mahallati, Salaheddin, 1523 Ray Rd., W. Hyattsville, Md. 20782
Martin, Luis G., 4614 Pen Lucy Rd., Baltimore, Md. 21229
Matz, Lola C., 1190 W. Belvedere Ave., Baltimore, Md. 21210
Mayer, Richard F., 912 Southwick Dr., Towson, Md. 21204
Mendoza, Ernesto P., 7933 St. Bridget Lane, Baltimore, Md. 21222
Merenyi, Dezso K., 1433 Limit Ave., Baltimore, Md. 21212
Meyer, Jon Keith, 5947 Pimlico Rd., Baltimore, Md. 21209
Morrison, Donald J., Jr., 4408 Independence St., Rockville, Md.
Muckle, Craig W., 8016 Seminole Ave., Philadelphia, Pa. 19118
Muir, Brockett, Jr., Our Lady's County, River Rd., Poolesville, Md.
Musinger, Jules, 7315 Keystone Ct., Forestville, Md. 20028
Niedermeyer, E. F. L., Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Md. 21205
Norris, John L., R.D. #1, Box 81, Havre de Grace, Md. 21078
O'Boyle, Tomas A., 57 Union St., Rockville, Conn. 06066
Oteiza, Jorge A., 1620 N. Franklin, Apt. 2, Wilmington, Del. 19806
Palacios, Esteban J., 700 N. Polk St., Little Rock, Ark. 72205
Pedroso, Frank, 691 Antrim Dr., Apt. 1-B, Newport News, Va. 23601
Perdomo, Gabriel S., 2114 Patapsco Ave., Baltimore, Md. 21230
Pereda, Francisco E., 97-1063 Dr., Rego Park, Queens, N. Y.
Pinheiro, Marcio V., 4410 La Plata Ave., Baltimore, Md. 21211
Poole, Peter E., 10201 Grosvenor Pl., Rockville, Md. 20852
Posen, Gerald Allan, 5930 E. Pratt St., Baltimore, Md. 21224
Prasclnik, Brandla, 1770 Normandy Dr., Miami Beach, Fla.
Price, Harold M., 11629 Regency Dr., Potomac, Md. 20854
Puig, Eliseo E., Main St., #301, Chattahoochee, Fla. 32324
Quintana, Fidel J., 8323 Draper La., Apt. 164, Silver Spring, Md. 20910
Ratner, Arnold Charles, 4118 W. Woodbine St., Chevy Chase, Md.
Ravenet, Luis, Milledgeville State Hospital, Milledgeville, Ga. 31062
Reynolds, James S., 11403 Clara St., Silver Spring, Md.
Rojas, Manuel de J., 146 49th St., Union City, N. J. 07087
Rose, James A., 5515 Alta Vista Rd., Bethesda, Md. 20014
Rosenquist, Glenn Carl, 1430 Francke Ave., Lutherville, Md. 21093
Santalla, Eusebio L., Rockland State Hospital, Orangeburg, N. Y. 10962
Schallenberg, Werner A., 1001 Pine Heights Ave., Baltimore, Md. 21229
Scott, Lewis P., III, 7004 Old Cabin Lane, Rockville, Md.
Shankman, Sidney, 1804 Metzerott Rd., Adelphi, Md.
Siegel, Leighton G., 5909 Western Run Dr., Apt. C, Baltimore, Md. 21209
Slocum, John P., 14009 S. Dunton Dr., Whittier, Calif. 90605
Smeets, Ronald M., 4907 Frederick Ave., Baltimore, Md. 21229
Smith, Ernesto P., 101 Perdue St., Beckley, W. Va. 25801
Solomon, Morton, 7533 Springlake Dr., Bethesda, Md. 20034
Spitz, Louis, 824 8th St., Laurel, Md.
Spratt, Robert H., 5 Pickens Lane, USNPP, Indian Head, Md. 20640
Stewart, George L., 4304 Federal St., Rockville, Md. 20853
Tinnin, Louis W., 6904 Redmiles Ave., Laurel, Md.
Torres, Melito M., 1628 Waverly Way, Baltimore, Md. 21212
Tsurumaki, Toshi, 1828 Metzerott Rd., #A-5, Adelphi, Md. 20783
Turbin, Stephen, 500 Congress Ave., Havre de Grace, Md.
Urso, Frank P., 14107 Bramble Lane, Laurel, Md. 20810
Van De Graaff, William F. R., Mt. Ephraim Farms, Snow Hill, Md. 21863
Vanderhoeven, Desire V., 3200 N. Calvert St., Baltimore, Md. 21218
Vela-Flores, Cristobal, 312 King St., Elkton, Md. 21921
Verges, Stephen F., Resmor Sanitarium & Hospital, Bethesda, Md.
vonKessler, Kirby L. C., 4 E. Madison St., Baltimore, Md. 21202
Wade, John C., 5946 St. Regis Rd., Baltimore, Md. 21206
Waller, Alfonso H., 35 Knickerbocker Rd., Demarest, N. J.
Wells, Sarah Lou, 105 Wiltshire La., Severna Park, Md.
Wensel, Louis O., 4232 E. 5th St., Tucson, Ariz. 85711
Whaley, Robert A., 97th General Hospital, APO 09757, N. Y., N. Y.
Wilkerson, Daniel C., Jr., 421 Regester Ave., Baltimore, Md. 21212
Wolf, Sanford R., 1278 Woodbourne, Apt. B3, Baltimore, Md. 21212
Work, Lon Buford, 5732 Keniston Ave., Los Angeles, Calif. 90043
Workman, John M., 742 E. Lake Ave., Baltimore, Md. 21212
Wright, Robert L., 860 E. Broad St., Elyria, Ohio 44035
Xirau, Jose F., 2213 Elder St., Apt. 4, Durham, N. C. 27705
Yeganeh, Mehdi L., 38 Maple Dr., Baltimore, Md. 21228
Yong, Junesik, 107 Old Line Ct., Ellicott City, Md. 21043
Yoon, Chan, Washington County Hospital, Hagerstown, Md. 21740
Ziegler, Thomas W., 1502 Outer Belt Dr., Houston, Tex. 77025

Names and addresses of above physicians received too late to appear in the Directory of Registered Physicians.



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At the same time, by diminishing overstimulation of the intestines, Lomotil relieves the abdominal cramps and discomfort so distressing to youngsters.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: may be habit forming)
atropine sulfate ..... 0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages,* given in divided doses, until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

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SPLENECTOMY IN THE TREATMENT OF HEMATOLOGIC AND NON-HEMATOLOGIC DISORDERS

The Annual J. M. T. Finney Fund Lecture



Dr. Coffey

Robert J. Coffey, MD, who will give this lecture on Wednesday, April 27, is professor of surgery and director of the Department of Surgery, Georgetown University Medical Center. Dr. Coffey was born in Elmira, NY, received his MD at Georgetown University Medical School, an MS in medicine and a PhD in surgery at the University of Minnesota. He served in the United States Navy for four years. Dr. Coffey is chief of surgery, Georgetown Division, District of Columbia General Hospital; consultant in surgery, U.S. Naval Hospital in Bethesda, the Andrews Air Force Base Hospital, and the Mt. Alto Veterans Hospital. He is president of the Southeastern Surgical Congress, governor of the American College of Surgeons, a member of several other surgical associations, and a licentiate of the American Board of Surgery. This year Dr. Coffey is president of the District of Columbia Medical Society.

MORE ABOUT THE CRUISE CONVENTION

Among the Annual Meeting speakers aboard the SS Argentina will be Doctors Faraino, Paulson, Peeler, and Dr. W. H. C. Masters of Bermuda. Last month this Journal contained information about the others who will give papers during the cruise convention: Doctors Cornbrooks, Mech, and Rappeport. Grand round films will be shown daily aboard ship.

Frank A. Faraino, MD, of Baltimore, will present a paper on Sunday, May 1, on the **"Surgical Treatment of Heart Block."** Attending this lecture will be the physicians of Bermuda, as well as the physicians on the cruise. After receiving his MD from the University of Maryland, Dr. Faraino interned at Mercy Hospital in Baltimore. Upon the completion of his general surgical training, he received training in thoracic surgery at the University, Baltimore City, and Mercy Hospitals. While in the US armed forces, he was chief of thoracic surgery at Lackland Air Force Hospital, San Antonio, Tex. Dr. Faraino is a member of the American College of Chest Physicians, the American Thoracic Society, and the American College of Surgeons. He is certified by the American Board of Surgery and the Board of Thoracic Surgery.



Dr. Faraino



Dr. Paulson

Moses Paulson, MD, is an associate professor of medicine at The Johns Hopkins University School of Medicine and physician at The Johns Hopkins Hospital. He will speak on **"Changing Concepts of Indeterminate Intestinal Inflammatory States and Their Management."** Dr. Paulson was born in Baltimore and received his BS and MD degrees from the University of Maryland. He was engaged in full time gastroenterologic research at The Johns Hopkins Hospital from 1929 to 1932. He continued his research on a part time basis until 1956. He conducted the gastrointestinal clinic there from 1943 to 1956. His studies concerned the etiology of ulcerative colitis, the medical management of the colon residing in situ in whole or in part after ileostomy performed for relief from ulcerative colitis, involving eventual restoration of intestinal continuity often in its entirety, the study of the virus of lymphogranuloma venereum in relation to ulcerative colitis, changes following human TOTAL gastrectomy including the hematologic sequences leading to pernicious anaemia; esophagoscopy and gastroscopy during active upper digestive tract hemorrhage; endoscopic appearances and behavior of the distal ileum after proctocolectomy and ileoanostomy for ulcerative colitis and intestinal polyposis; the incidence of intestinal parasites in the temperate zone, and the first demonstration of residual hepatic damage following infectious hepatitis.

He is author or co-author of 50 publications, including contributions to sections or chapters to systems of medicine and several books. He is now editing Paulson's **Gastroenterologic Medicine,** to be published by Lea & Febiger.

"Waldenström's Macroglobulinemia: A Family Study" is the title of a paper to be given by **Richard N. Peeler, MD,** of Annapolis. Dr. Peeler was born in Salisbury, NC, attended Catawba College, and received his MD degree from The Johns Hopkins University School of Medicine. He served an internship and assistant residency at The Johns Hopkins Hospital, followed by a fellowship in immunology and infectious disease. Dr. Peeler, who is in the private practice of internal medicine in Annapolis, is chief of medical service at the Anne Arundel General Hospital and instructor in medicine at The Johns Hopkins. He is a fellow of the American College of Physicians.

168th ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULT

April 27 and 28 at the Alcazar, Baltimore

HOUSE OF DELEGATES MEETINGS

Osler Hall, Faculty Building
211 Cathedral Street, Baltimore

TUESDAY, APRIL 26—8 PM
FRIDAY, APRIL 29—9 AM

All members welcome

WEDNESDAY, APRIL 27
The Alcazar

AM

10:00 RELATIONSHIP OF VASCULAR THROMBOSIS TO SYSTEMIC DISEASE
Standish McCleary Fund Lecture
Donald G. McKay, MD
Columbia University

10:30 PHAGOCYTOSIS AND DEGRANULATION
William Royal Stokes Memorial Fund Lecture
James G. Hirsch, MD
Rockefeller Institute

11:15 FAMILIES AND PHYSICIANS
George M. Boyer, MD Fund Lecture
John Parks, MD
George Washington University

WEDNESDAY, APRIL 27

Park Plaza Hotel, Baltimore

12:30 PM **ROUND TABLE LUNCHEON**

A luncheon with the experts—24 different medical topics and moderators from which to choose. An opportunity for an informal informative discussion

PM

2:15 URINARY STASIS AND URINARY INFECTIONS IN FEMALE PATIENTS
J. Mason Hundley Annual Lecture
Houston S. Everett, MD
The Johns Hopkins University

2:45 MEDICINE'S RESPONSIBILITY IN THE POPULATION EXPLOSION
I. Ridgeway Trimble Fund Lecture
H. Curtis Wood, Jr., MD
Assn. of Voluntary Sterilization

3:30 SPLENECTOMY IN THE TREATMENT OF HEMATOLOGIC AND NON-HEMATOLOGIC DISORDERS
J. M. T. Finney Fund Lecture
Robert J. Coffey, MD
Georgetown University

8:30 ALCOHOLISM AND THE LAW
A Medicolegal Symposium
Frank L. Iber, MD
Harry E. Shelley, LLB, ThB
Robert C. Embry, Jr., LLB

SEE THE EXHIBITS

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APRIL 27 and 28

New and practical information in every exhibit

THURSDAY, APRIL 28
The Alcazar

AM

10:00 TUMOR VIRUSES AND VIRUS TUMORS
Harvey Grant Beck Memorial Lecture
Alan S. Rabson, MD
National Institutes of Health

10:30 SYPHILIS: THEN AND NOW
Rudolph H. Kampmeier, MD
Vanderbilt University

11:15 PERCUTANEOUS CORDOTOMY AND THE MANAGEMENT OF SOME INTRACTABLE PAINS
John (Sean) F. Mullan, MD
University of Chicago

NO REGISTRATION FEE — CREDITS GIVEN BY ACADEMY OF GENERAL PRACTICE

ALL physicians and paramedical personnel are INVITED TO ATTEND the above sessions, including the Bermuda Cruise Convention

A detailed program will be mailed to all members, and to others upon request

John Collins Harvey, MD, chairman, Committee on Program and Arrangements

April 29–May 4, Bermuda Cruise Convention, aboard SS Argentina

PM

2:15 POSTGASTRECTOMY SYNDROMES
Amos R. Koontz, MD Memorial Lecture
Walter F. Ballinger, II, MD
The Johns Hopkins University

2:45 CARCINOMA OF THE STOMACH
Amos R. Koontz, MD Memorial Lecture
Robert W. Buxton, MD
University of Maryland

3:30 ORGAN TRANSPLANTATION: REFLECTIONS OF THE HOST'S RESPONSE AND ITS MODIFICATION
Jesse C. Coggins Fund Lecture
Gustave J. Dammin, MD
Harvard Medical School

THURSDAY, APRIL 28

Sheraton-Belvedere Hotel, Baltimore
6:15 PM Reception
7:15 PM Presidential Dinner

Entertainment
Betty Beneé—vocalist
Larry Wilde—MC and comedian


Betty Beneé


Larry Wilde

HEALTH EVALUATION TESTS
available to
Members of the Faculty
WEDNESDAY and THURSDAY, APRIL 27 and 28
8 30 AM—5 PM
The Alcazar, Baltimore

APRIL 29—MAY 4
SS Argentina
Bermuda Cruise Convention

W. H. C. Masters, MD, ChB
Bermuda Medical Associates Member of Parliament

ENDOMETRIAL ASPIRATION BIOPSY
Ernest I. Cornbrooks, Jr., MD
University of Maryland

SURGICAL TREATMENT OF HEART BLOCK
Frank A. Faraino, MD

SURGICAL CONSIDERATIONS IN CASTRO-INTESTINAL BLEEDING
Karl F. Mech, MD
University of Maryland

MANAGEMENT OF INTESTINAL INFLAMMATORY DISEASES OF UNKNOWN ORIGIN
Moses Paulson, MD
The Johns Hopkins University

WALDENSTRÖM'S MACROGLOBULINEMIA: A FAMILY STUDY
Richard N. Peeler, MD
The Johns Hopkins University

SEX IN MARRIAGE COUNSELING
Jonas R. Rappeport, MD
University of Maryland

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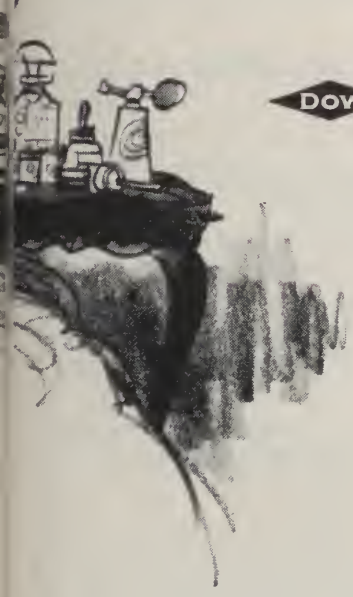
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

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VENEREAL DISEASE FILMS AVAILABLE

Several films which stress the dangers of venereal disease and the vital importance of early recognition and treatment may be borrowed without charge in Maryland from the State Health Department. Facts are presented dramatically and impressively, and the terminology is tailored to lay audiences. Physicians may find these brief descriptions helpful in answering inquiries regarding visual aids for use by schools, clubs, community groups, and other organizations interested in health education:

The Innocent Party, an 18-minute color film, features a student who has contracted syphilis through a casual encounter in a nearby town and has transmitted it to a young girl in his own community. Appropriate for general audiences, it is recommended especially for showing to teenage groups and young adults.

Dance, Little Children, a 25-minute color film, describes the course of a syphilis outbreak among 12- to 19-year-old boys and girls. One boy's impulsive "pick-up" starts a chain of infection that results in 50 venereal disease cases in a small community. Parental attitudes, prompt medical care, and health department action to safeguard public health are emphasized. This picture is suggested for use by adult moderators of youth groups, teachers and adult organizations.

A Quarter Million Teenagers, a color filmstrip, shows in 70 graphic pictures the types of organisms which produce syphilis and gonorrhea, early symptoms in boys and girls, how the diseases spread unless treated promptly by a physician, and the tragic effects on individuals and unborn children. It is recommended for showing to junior and senior high school and college classes. A 16-minute color motion picture with the same title and content also is available.

Message to Women, a 20-minute color film on syphilis and gonorrhea, emphasizes to mothers the importance of informing their daughters regarding the risk of venereal disease. Animated charts illustrate the effects of these diseases in women. This presentation is particularly appropriate for parent education groups, parent-teacher associations, and women's organizations. It is suitable also for senior high and college students.

Films and filmstrips for use by professional personnel engaged in venereal disease control include:

Identification of Early Syphilis, a 30-minute color film, stresses the importance of suspecting syphilis in office patients and the necessity of being able to recognize the early signs.

Introduction to the Fluorescent Treponemal Antibody Test, a nine-minute color film, illustrates the preparation of treponemal antibody antigen and demonstrates the technique of staining with fluorescent material. It also pictures reactions obtained by means of ultraviolet light microscope assembly and the method used in the preparation of tagged globulin and its chemical purification.

Diagnosis of Primary Syphilis, a filmstrip with tape recorded narrative, indicates some common errors in diagnosis of syphilis, the location of lesions, and differences between syphilitic lesions and the lesions caused by other diseases.

All of the films may be borrowed from the film library, Maryland State Department of Health, 301 West Preston Street, Baltimore.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

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recurrent G.I. upset

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Scheri

ıew Ltrafon ielps restore the ppetite for ife



Whe the patient's symptom pattern and the absence of physical findings confirm your suspicion of a depressive state, ETRAFON w sua reverse the mental and functional slowdown—and allay the anxiety that accompanies depression. "...*it is rare to find a depress atie who does not also present definite symptoms of anxiety.*"[1]

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TRAF *offers the flexibility and convenience of 2 iditi il dosage strengths: (1) For more severe cases ith p ominant anxiety*—ETRAFON-FORTE *(amitrip- line Cl 25 mg. and perphenazine 4 mg.); (2) for ioles t or geriatric patients*—ETRAFON-A *(amitrip- line Cl 10 mg. and perphenazine 4 mg.).* S-915

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The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

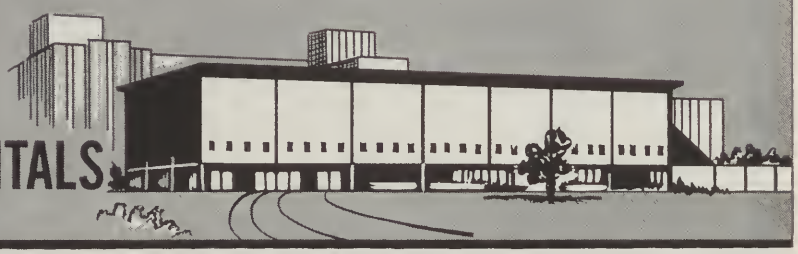
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HISTORY OF THE BALTIMORE CITY HOSPITALS

BY DOUGLAS CARROLL, M.D.



Chapter 3.— The Almshouse at Calverton: The Beginning of Social Medicine (1822-1840)

Every one of these establishments (jail, penitentiary, insane asylum, and almshouse), appeared to be strongly marked with the effects of that active desire to contribute to the wants of the wretched, which we met with in all parts of America, but in no place more conspicuously than Baltimore (1830).[1]

The new Almshouse was located in the area now bounded by Pulaski, Presstman, Lexington, and Franklin Streets. Although it had formerly been the country seat of the Smith family, a worse location could hardly have been found, from the point of view of public health, sewage disposal, and mosquito-borne disease. Calverton was a large private dwelling improved by two wings, 130 by 40 feet each. On December 2, 1822, 533 paupers were moved to the new Almshouse. Its major purpose remained the care of the infirm, orphans, paupers, the insane, and vagrants. In 1823, the first patients were sent there because of sickness.

State of Medical Practice at Calverton

The state of medical practice in this period was little better than in the time of Galen (130-200 AD). Physical examination consisted of palpation of the pulse, and the laboratory work consisted of looking at the urine in sunlight. Tuberculosis, malaria, dysentery, typhoid, and typhus could not be differentiated by any objective laboratory test. In 1831, a great influx of sick immigrants put an increased burden on the Almshouse.

Dr. T. H. Buckler[2] (1812-1901) described the Almshouse at this period:

> A single case of erysipelas brought to the house would often in a very short time spread the infection to all the other wards, rendering it dangerous to perform the most simple operation, even that of bleeding. It was not unusual to see in the same ward, at the same time, cases of typhoid fever, erysipelas, dysentery, and typhus or ship fever. Every summer the children suffered from cholera infantum, and where they escaped this disease, they were almost sure to perish in the winter with pneumonia. In the whole history of the establishment, there is no single example of a foundling that lived to the age of three years.

A cholera epidemic in 1832 killed 125 of 502 people in the Almshouse in a period of two weeks.

Reporting in 1828, the trustees stated that the Almshouse must be an infirmary for the indigent sick, a lying-in hospital for the indigent, a workhouse for vagrants, and asylum for destitute children, a lunatic hospital, and a medical and surgical school. One can well imagine the bedlam.

Some Advanced Views of Medical Care

Phillipe Pinel (1755-1826) in France and William Tuke (1732-1822) in England were leaders in improving the care of the mentally ill by "moral treatment." In America, it was Benjamin Rush (1745-1813), steeped in the liberal writings of John Locke (1632-1704), who did much to stimulate concerned interest in mental illness.

The Maryland Hospital at Baltimore (which became a state insane asylum in 1828) was one of four hospitals in the United States which

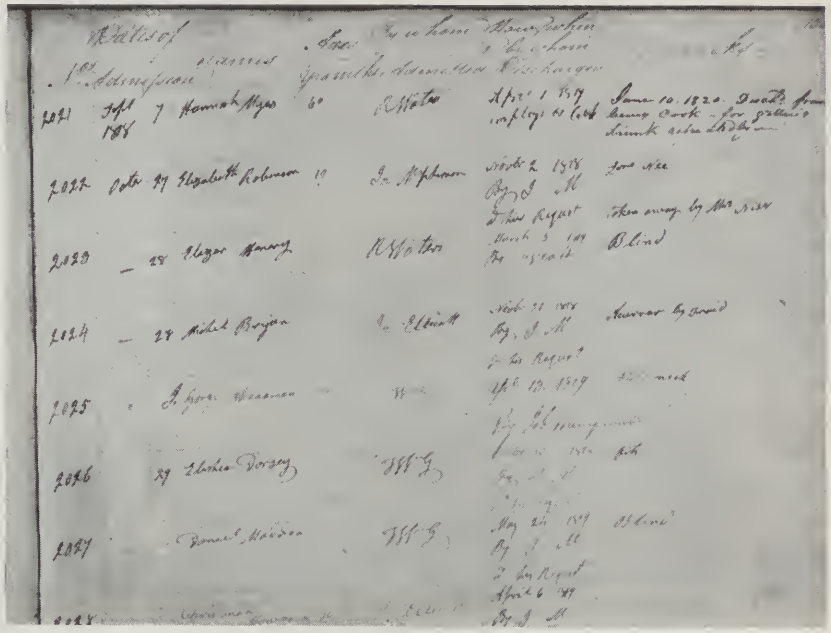


Fig 1
Almshouse Admission Book, September, 1818.



Fig 2
The Almshouse, Calverton. Fielding Lucas, 1832. (Original in Maryland Historical Society)

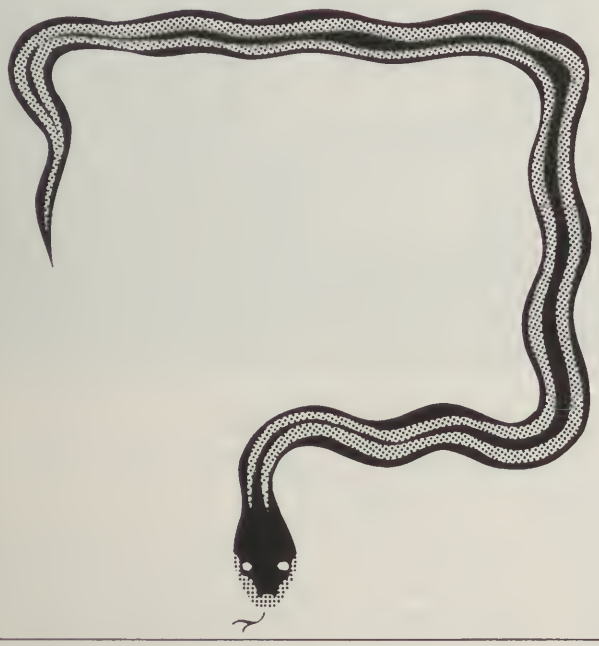
accepted mentally ill patients at the beginning of the nineteenth century. These patients were treated in spacious, well-lighted rooms with good food and by physicians informed by the moral treatment movement.[3] "Moral" meant psychological or non-organic. Although Plato had understood human behavior in terms of the person's situation, heredity, and education, this insight gave way, during the Dark Ages, to a demonic and essentially irrational interpretation of mental illness. The new scientific and humanitarian attitudes adopted in the eighteenth century involved the belief that behavior was based on natural law rather than possession by demons. Both humanism and scientific thought suggested that the individual did not have complete control over natural law. Therefore, there was no absolute standard of individual responsibility, and men were not completely responsible for their actions. These attitudes led to more humanitarian treatment of criminals, paupers, and the psychotic insane.

Some diagnoses made at the Almshouse in 1829 were "disappointed affection," "indulgence of passion and pride," and "religious perplexity." These were moral, or psychological, diagnoses and suggest that the care of the insane at the Almshouse at this period was humane, sophisticated, and modern.

Other broader influences were at work. In the 1830's, America was rapidly developing a new liberal philosophy of the individual. American thinkers were turning to nature in search of

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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truth. Societies for the abolition of slavery were being formed. Experiments in communal living were underway. New England Puritanism was growing milder. Leaders with social vision and humanistic ideals were rising to social leadership. Benjamin Franklin, Thomas Jefferson, Thomas Payne, and later Emerson, Channing, and Samuel Gridley Howell created a prevailing spirit of humanistic ideals and interest in human problems.

During the late 1820's it became evident that Baltimore City was unable to take care of the large number of insane being sent to the Almshouse. The state began to take care of a few of the insane. Over the next century this need remained unmet until a system of state mental hospitals was organized.

Social Factors in Pauperism and Disease

About 1825, the trustees of the poor took under consideration the large population of able-bodied paupers in the Almshouse. Of 623 adults admitted in 1825, 554 were found to be reduced to poverty by drunkenness. The trustees attributed pauperism largely to alcoholism. Several later surveys showed that a great majority of the children admitted for non-support or broken families had alcoholic parents.

The alcoholic theory of poverty was not entirely satisfactory as an explanation of indigency. The social and individual psychological causes of alcoholism were not considered. The alcoholic theory of indigency allowed Puritan moralism and judgment to replace objective consideration of the problems of the Almshouse inmates. The theory allowed the trustees to be satisfied with the Almshouse as it was. A similar attitude was being reflected in the English Reform Bill of 1832 and the Poor Law of 1834, by which workhouses were established and paupers were required to choose between what amounted to the punishment of the workhouse or starvation. In America, the view that the poor were largely responsible for their poverty was supported by the Puritan heresy, peculiarly identified with the American rugged individualistic "self-made" man, that God is identified with human success, and that indigency is the result of moral failure.

In 1828 and 1829, the trustees noted that the liberal admitting policies of the Almshouse had drawn paupers from neighboring counties as well as Pennsylvania and Virginia. They attempted to tighten the admitting policies of the Almshouse.

In the 1830's began tremendous immigrations from Nova Scotia, Germany, and Ireland. Many of these immigrants were sick on arrival and had to be taken care of in the Almshouse. The plight of such people was recognized by the Trustees of the Poor, and they were accepted without question. It is apparent that in many cases the city of origin of the immigrants had paid their passage to Baltimore to get rid of them because they were a burden on the community from which they came. Although the law required residence of about a year before people were eligible for Almshouse admission, these eligibility requirements were swept aside because of the large number of sick immigrants. Many patients were admitted to the Almshouse directly from the ships on which they had arrived.

In the surveys made by the trustees of the place of residence of people being admitted to the Almshouse, we see the beginning of "scientific philanthropy," the investigation of each case individually. The search as to the origin and cause of the person's poverty was an effort in the same direction. Although alcoholism was probably a simplified answer as to the cause of poverty, the effort to find a cause and the division of inmates into the "deserving" and "undeserving" poor was a step in the development of modern social work and its principal tool, casework. The deserving poor, such as the insane and children, were given special consideration and were treated as special groups either by the state or by private charities.

During the years 1822 to 1840, the cost of the Almshouse seemed to be the major point of orientation. It was run cheaply and efficiently largely because of the cheap vagrant labor available for the farming operation.

Thus, although epidemics flourished, there was growing interest in the causes of poverty, in psychological treatment, and in the financial integrity of the Almshouse.

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1. Stuart, James: *Three Years in North America,* 2 vols. New York, 1833.
2. Buckler, T. H.: *History of Epidemic Cholera as It Appeared at The Baltimore City and County Almshouse in the Summer of 1849,* Baltimore, 1851.
3. Bockoven, J. S.: Moral Treatment in American Psychiatry, *J Nerv Ment Dis* 124:167, 292, 1956.



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COMPONENT MEDICAL SOCIETIES



BALTIMORE COUNTY

Baltimore County General Hospital was host to the Baltimore County Medical Association and Woman's Auxiliary on January 19. **John Sargeant,** executive secretary of the Medical and Chirurgical Faculty, spoke on "1966 Legislative Prognostications." He said that at least four bills of interest to physicians will be introduced in the State Legislature. The details of these bills can be found in *The Assemblyman,* published by the Faculty. He also reported that in conjunction with Medicare, Blue Shield will probably introduce a supplemental program costing about $2 a month for persons over 65 to cover the deductible part of Medicare.

President Edward L. Krieg introduced **William G. Esmond, MD,** who plans to initiate an intermittent hemodialysis clinic at St. Joseph's Hospital. The Association endorsed this program.

Baltasar Velez, MD, and **Everett Diggs, MD,** were welcomed as new members.

Raymond Cunningham, MD, chairman of the Hospital Coordinating Council, reported that he had written letters to representatives of three hospitals in Baltimore County suggesting that they have their staff meetings and invite other hospital staffs to attend so that physicians would not be required to attend so many staff sessions.

The President stated that he has had many requests for speakers for PTA meetings, Health Career Days, etc., and he appointed **Frank Faraino, MD,** to organize a Speaker's Bureau.

The matter of the special assessment was brought up. Dr. Krieg read from the Faculty Bylaws, which states that anyone not paying the special assessment will be dropped from membership as of March 1, 1966.

Gordon Grau, MD, program chairman, announced that the February meeting would be held at the Western Electric complex in the Industrial Park near Cockeysville. **Samuel Bacon, MD,** medical director of the Western Electric plant, will arrange the program.

John Snyder, MD, chairman of the Board of Governors, reported a good response to our request to the component societies of the Faculty that they write to the Medical and Chirurgical Faculty to request the Medical Care Council to include in its budget enough money to pay the "usual and prevailing fee" for the treatment of the medically indigent in Maryland.

Charles H. Williams, MD

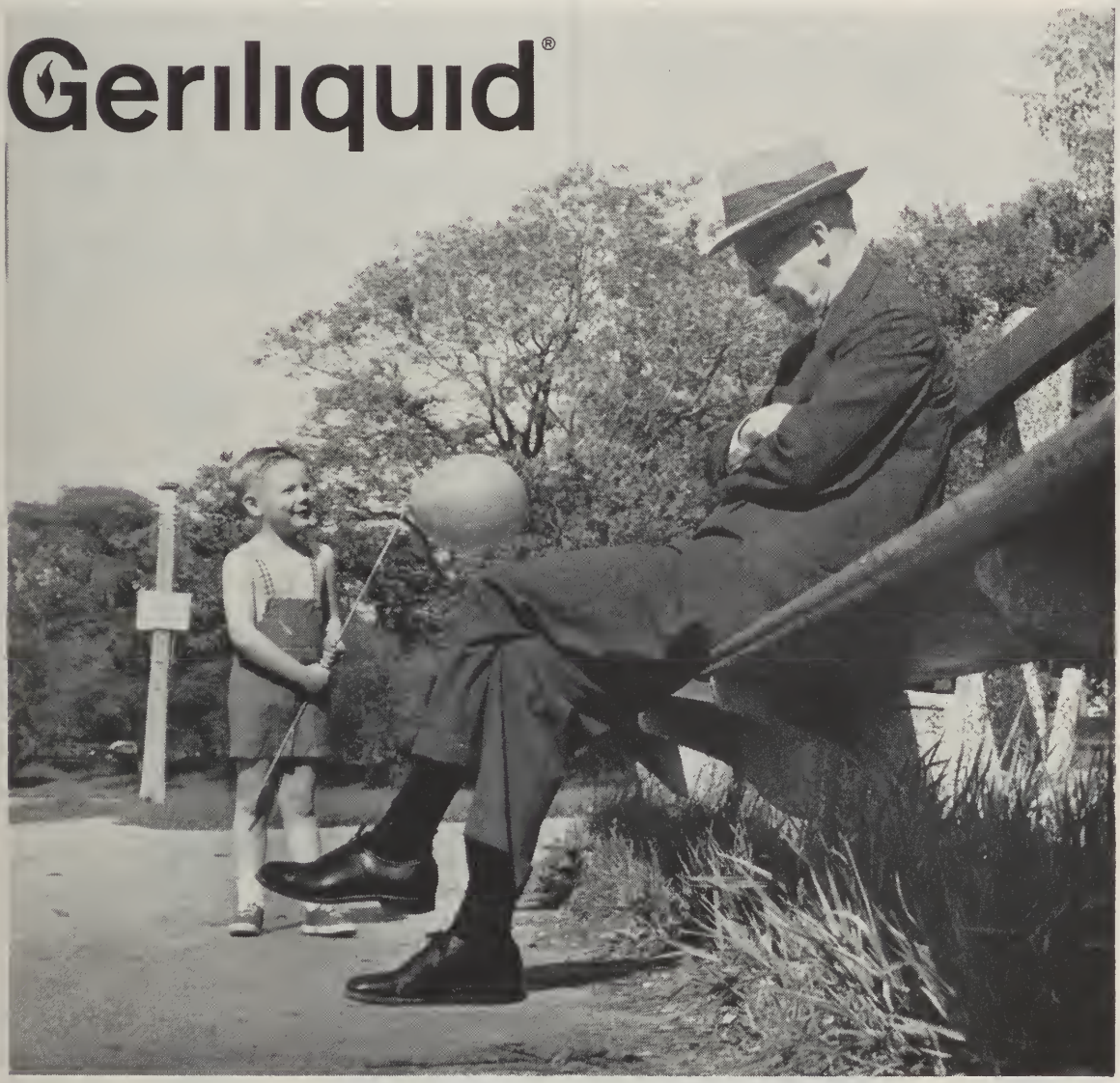
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WASHINGTON COUNTY

Education for premedical students, practicing physicians, and medical technologists was on the agenda of the January meeting of the Washington County Medical Society.

Donald Benson, MD, professor of anesthesiology at The Johns Hopkins University Medical School and anesthetist-in-charge at Johns Hopkins Hospital, discussed "Cardiopulmonary Resuscitation" to the group of more than 70 physicians and 16 nurses.

Plans to allot $1,200 a year for scholarships were approved. Each year a local student will be selected to receive an annual scholarship of $300 to be used in the undergraduate premedical training. This will continue during the four years of college. In addition, another student will be selected each year to receive the same amount. The current recipient is Norman Haines of Boonsboro, a sophomore at The Johns Hopkins University.

To overcome the acute shortage of properly qualified medical technologists, **Fred Shillinger, MD,** pathologist at the Washington County Hospital and a member of the society's Public Health and Legislation Committee, presented a resolution to be acted on by Med-Chi. He recommended that a program be instituted in the state to train people so vitally needed in hospitals.

The first in a series of awards to be presented to local laymen was given to Mrs. Vi Birdsall, owner of the Physicians Answering Service in Hagerstown. The framed certificate was awarded "for outstanding service by a layman to the field of medicine."

State legislators from Washington County were guests at a luncheon meeting held in early January by the Public Health and Legislation Committee.

Jack Beachley, MD, chairman, led the discussion of current medical legislation being considered for the current session of the legislature.

* * * * *

The Public Relations Committee has adopted an eight point program for the coming year. The projects are continuing the Speakers Bu-

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

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CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

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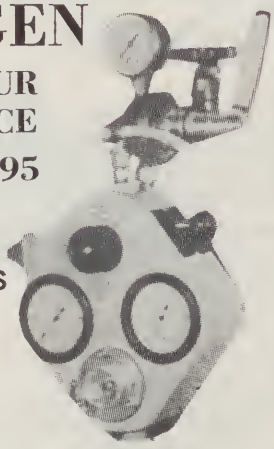
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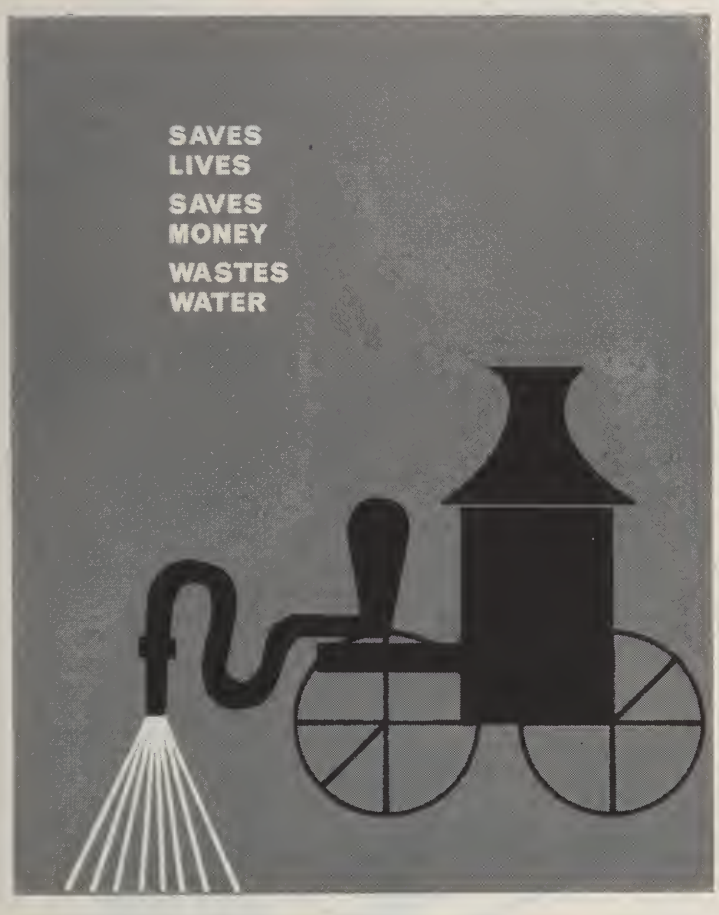
Richard A. Young, MD, presented a pin to George Kohler, MD, Smithsburg, for 50 years of membership in the Society. Since opening his office in 1913, Dr. Kohler has delivered 5,423 babies. He has one more to deliver this spring, the fourth generation in one family.

reau, participating in the Health Fair in November, holding a seminar on the health aspects of sports for scholastic coaches and trainers, to be held in the spring, and distributing AMA pamphlets and a roster of physicians to newcomers through the Welcome Wagon.

Also planned are a program of support and publicity for the local ambulance services, an advisory board of physicians to assist the Board of Education, awards to laymen who have performed outstanding service to medicine, and completion of a code for news media.

The society has opened an office in the old nurses home of the Washington County Hospital. The executive secretary will have office hours there daily. This will be not only a place for the transaction of society business but also a meeting place for the Executive Committee of both the society and the Woman's Auxiliary.

Mrs. Joyce Harlacher



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WICOMICO COUNTY

Edward R. Annis, MD, immediate past president of the AMA, was guest at the January meeting of the Wicomico County Medical Society, Inc. Speaking to an audience of more than 100, Dr. Annis exhorted physicians to become "more active citizens" and reminded them that unless they participate in establishing rules and regulations for Medicare, someone else will.

Reviewing the many activities of the AMA in scientific and educational fields, Dr. Annis said that the rapid funneling of legislative and other information to the county level is not a feasible project for that organization. To provide a mechanism for this purpose and to offer a forum where county medical society problems can be discussed, the Congress of County Medical Societies was formed. Far from competing with AMA, the Congress proposes to supplement AMA's work at the county component level.

Dr. Annis was introduced by **Andrew C. Mitchell, MD,** immediate past president of the Wicomico County Medical Society. The meeting was conducted by **Charles Bagley III, MD,** president. Arrangements for the dinner, which was held in the auditorium of the Peninsula General Hospital School of Nursing, were made by the Woman's Auxiliary to the Wicomico County Medical Society, of which **Mrs. William C. Morgan** is president.

Guests at the meeting included members' wives, representatives of local news media, presidents of several Eastern Shore medical societies, and representatives of the Peninsula General Hospital.

While in Salisbury, Dr. Annis also spoke on sex education before three groups of high school students and made appearances on television and radio.

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Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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THE POST MORTEM EXAMINATION TO BE (USEFUL) OR NOT TO BE!

A REBUTTAL

W. BRADLEY KING, JR., MD

In an illuminating symposium on the autopsy, published in the September 6, 1965, issue of the *Journal of the American Medical Association,* the autopsy was dissected and its usefulness assessed. The approaches were several: its importance in the molecular age, its significance as a research tool, its general use, and its problems and proposed solutions.

The principal complaint about the autopsy (probably not as good a term as *post mortem examination,* which etymologically has a broader interpretation) has been its apparent inability to keep pace with the increasingly sophisticated and specific techniques of diagnosis and therapy, ie, its failure to change its methods significantly since the days of Virchow and Rokitansky. Thus, in the face of fancy gadgets and elaborate clinical determinations in diagnostic or therapeutic maneuvers, it has lost face—though in no way being different in this regard than the time-honored techniques of history-taking and physical examination, which also have changed but little.

To imply that the post mortem examination has been stagnant is to avoid the many morphologic discoveries, such as the recent establishment of alveolar proteinosis as a disease entity; to overlook its position in the understanding of the anatomic changes in many biochemical aberrations, such as hypo- and hyperkalemia; or to ignore its anatomic verification of sites of virus-induced lesions, such as that of Coxsackie B myocarditis.

A maxim taught early in one's training in pathology is that it is difficult to transpose accurately and consistently structural changes into function. But even this "failing" is weakening with the advent of the newer ancillary laboratory techniques of post mortem examination, such as electron microscopy, cytology, immunology, microbiology, toxicology, histochemistry, cytogenetics, and virology injection studies. The big problem seems to be the apparent failure to use such techniques in the autopsy examination.

Recognizing that these techniques are not being used as often as may be desired is to avoid some obvious problems intrinsic to the examination of a dead body: virtually all the biochemical components of the body become so modified after death that tests for them are no longer reliable, and microbiologic studies are apt to be complicated by post mortem invaders. Even such an apparently simple determination as the time of death cannot be made with accuracy. Frequently, the elapse of time between death and the actual performance of the post mortem examination further magnifies these problems.

Lack of time causes additional problems. The increasing dominance of clinical pathology in the professional life of the practicing pathologist, as well as the short supply of pathologists, are two of several explanations. But academic pathologists, too, are frequently unable to do as thorough a job on the post mortem examination as might be possible. So, even with newer techniques available, there is not enough time to use them. The lack of pathologists, however, is not the whole story. Adequate paramedical personnel

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are so scarce that even in the rare event of having equipment, space, time, and the inclination, there still may not be enough people to do this additional work. Now and in the future, with the ever-increasing need for laboratory technologists and technicians to keep up with the demands of rapidly growing clinical laboratories, having enough technical personnel to carry out this autopsy work may be almost impossible.

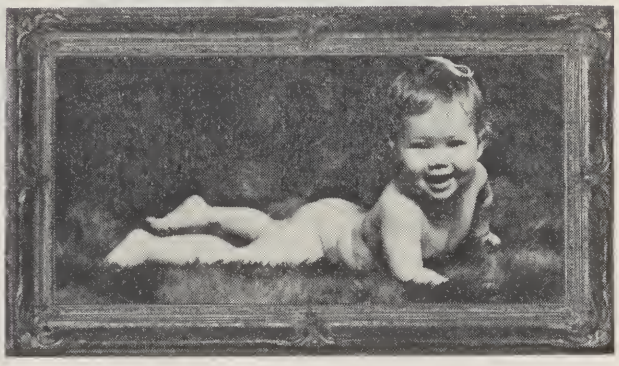
One of the most discouraging things is that often the most pathologically interesting cases have minimal or inadequate clinical workups. This is every bit as frustrating as having a clinically well worked-up case in which the anatomic pathologic findings are minimal or inadequate to explain the changes perplexing the clinicians. Apropos of this, some autopsies are so limited by permission or so rushed that the pathologist may be restricted to the simplest techniques.

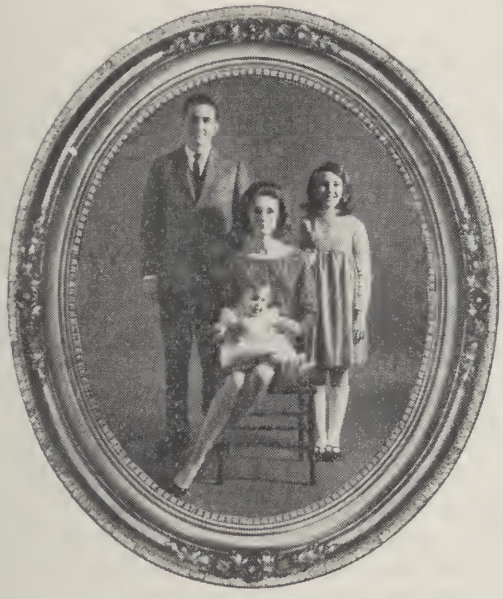
In summary: 1) The post mortem examination is still useful, for even though many autopsies are performed with the most "ancient" techniques, and perhaps even under adverse circumstances, they still may provide information not available by *any other* diagnostic maneuver (and the medical examiner case is noteworthy here). 2) Pathologists have serious problems: lack of time, personnel, equipment, space, and funds, which impede their doing what might be considered the ideal post mortem examination. 3) Post mortem changes in the body anatomy and chemistry preclude many determinations possible during life. 4) There is a real need for more thorough clinical workups on many patients, with more thoughtful laboratory (clinical, cardiopulmonary, radio-isotope, etc.) determinations not restricted by lack of patient or hospital funds (but, rather, perhaps subsidized by research monies), which not only will aid the patient who is to recover but also will provide information for the post mortem pathologist in the event of therapeutic failure.

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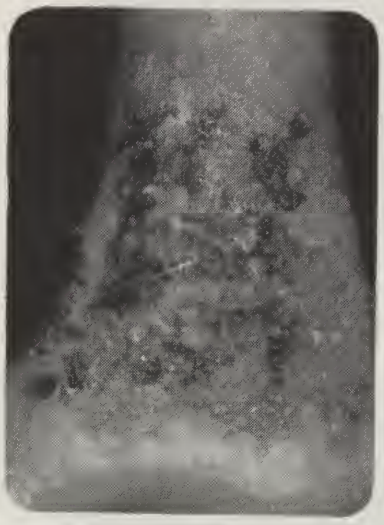
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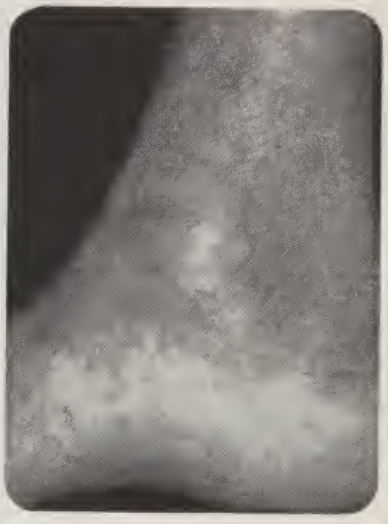
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The Heart Page

Joseph C. Fitzgerald, MD—*Editor*

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

VOCATIONAL REHABILITATION OF THE CARDIAC PATIENT

JACK R. NICHOLS

Vocational rehabilitation has the capacity for being the physician's culminating service to the cardiac convalescent. This program of counseling and employment exploration coupled with the physician's medical treatment can spell the difference between despair and hope for the recuperating cardiac patient.

The Division of Vocational Rehabilitation in Maryland is part of the State Department of Education. Its function is to evaluate, counsel, train, and place handicapped persons in jobs. The cooperation of the treating and consulting physicians is essential to the success of this program.

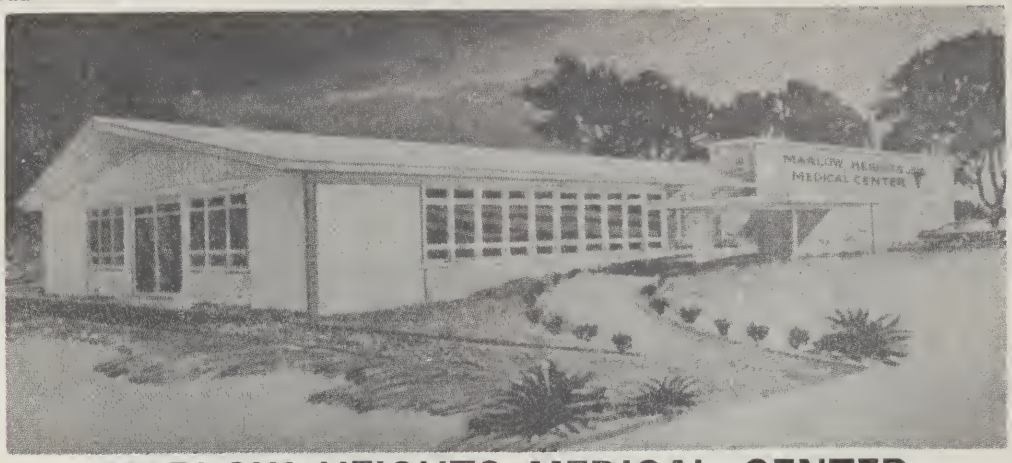
Only the physician, through his training and experience, is able to identify the physical restoration process of the recuperating cardiac patient. When this is relayed to the trained and experienced vocational rehabilitation counselor, it can be converted into meaningful job specifications and opportunities. As a liaison between medical services and employers, rehabilitation counseling may determine the difference between months or even years of inactivity and a gradual resumption of former occupational skills. The key is wholehearted cooperation between the physician and the vocational rehabilitation counselor. With a team effort, the cardiac patient can better look forward to a safe resumption of employment.

The patient with a cardiac history is one of the most difficult clients to rehabilitate successfully into remunerative employment. A tremendous amount of resistance must be overcome when employment opportunities are sought. Employers are afraid to employ former cardiac patients because they envision an uncertain future. Therefore, it is initially the job of the counselor to enlighten the employer about the cardiac patient who is being presented for employment. To do this the counselor needs to have the physician's evaluation of the patient and his limitations. From the physician's experience in dealing with many cardiac patients will come practical guidelines for each patient that he encounters. The counselor can use this information to obtain the best type of employment within the limitations of the disability.

A patient's return to employment is initially sought in some capacity related to his previous occupation. If the working conditions and demands can be altered so that he can return safely, quite often he can use skills that he already has. This results in a great conservation of skilled craftsmen and ordinarily insures a wage comparable to that earned before the onset of the disability.

When the patient is unable to return to his former employment because of the strenuous physical demands, the rehabilitation counselor attempts to help him use the existing skills in a related industry. Again this results in the conservation of the skill and, usually, a higher starting wage.

Mr. Nichols is district supervisor, Eastern Shore District, Division of Vocational Rehabilitation, State Department of Education.



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When a person cannot return to some phase of his former employment, the vocational rehabilitation counselor then determines the potential and possibilities for retraining to develop a skill that will enable the cardiac patient to secure satisfactory job placement. If training is not indicated because of age, ability, or interest, direct placement efforts are initiated to effect employment in a job commensurate with the cardiac's physical capabilities.

Vocational rehabilitation thus offers to a physician an extension of his services to effect the total rehabilitation of his patient. Hopefully, the physician will welcome this assistance in counseling as his demands from acute illness necessarily limit his participation in detailed and continuous counseling of each recuperating cardiac. A close relationship should exist between the physician and the counselor so that employment demands can be appraised objectively in the light of each patient's physical condition. With this cooperation, a more orderly resumption of occupational duties will result, and a contributing member will be restored to society.

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The first of three simplified leaflets based on the Heart Association's sodium-restricted diet booklets is now available to physicians and other professional workers. Like the booklets, it may be obtained by patients only if they present a physician's prescription. It is available from local Heart Associations.

Entitled "Sodium Restricted Diet, 500 Milligrams," the leaflet was developed in cooperation with the Heart Disease Control Program of the U. S. Public Health Service and The American Dietetic Association. Although the diet is the same, the leaflet contains less detail than the 56-page booklet from which it was adapted. Completely unfolded, it becomes a 20x14 inch chart suitable for posting in the kitchen. In addition to the daily diet plan and food lists, the leaflet carries important information on sources of sodium, shopping and cooking, eating out, and seasonings.



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DOUGLAS G. CARROLL M.D.
EDITOR

THE HEART ASSOCIATION OF MARYLAND AND ITS CHAPTERS

Where patients with heart and circulatory diseases are concerned, the Heart Association of Maryland and its local chapters should be counted as a first resource. Chapters are located in Cumberland, Hagerstown, Frederick, Kensington, Riverdale, Bel Air, Easton, Salisbury, and Baltimore.

Most prominent among the services available to practicing physicians through the Heart Association are:

1. **Work Evaluation Unit.**—On physician referral, through his local Heart Association chapter, a patient is given an appointment for evaluation at this unit, located in Baltimore, to determine his work capacity in relationship to his occupational potential. There is no charge for this evaluation, which includes a medical work-up by a cardiologist, interviews and evaluations from a psychiatrist, vocational counselor, and medical social worker. After a joint team conference, a work prescription and recommendations are discussed with the patient and formally reported to the referring physician.

2. **Loan Closet.**—Sick room equipment such as hospital beds, bed sides, commodes, and wheelchairs are available through local Heart Association chapters if, in the opinion of the physician, it would create a hardship for the family to rent or purchase such equipment.

3. **Rheumatic Fever Prophylaxis.** — The Heart Association maintains a registry of rheumatic fever patients in Maryland. A physician may register such a patient by filling in a form provided by the Association. Patients who would find it a financial burden to pay the commercial rate for penicillin or sulfadiazine may be referred. Upon referral, the Heart Association sends a card to the patient which he uses in applying to the local pharmacy for low-cost penicillin. In this instance, also, the Heart Association relies upon the physician's judgment as to the patient's financial eligibility.

4. **Information Services.**—The Heart Association carries an up-to-date file on community resources for the cardiac patient. Information is available to physicians, their patients, and their families on such subjects as occupational therapy in the home, meals on wheels, financial assistance, and home nursing care. If a question is asked on which the Heart Association has no information, a concerted effort is made to find the answer.

5. **Educational and Informational Literature.**—Pamphlets, brochures, leaflets, and wall charts are available to the physician, upon request, to help him inform his patients and their families about the diagnosis, management, and prognosis. A catalog of these pub-

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FOR THE PATIENT

Aphasia and the Family
Strokes—A Guide for the Family
Do It Yourself Again (an explanation of and catalog of self-help devices)
What You Should Know About Rheumatic Fever
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6. **Scientific Sessions** for physicians, nurses, and paramedical personnel to bring the latest techniques to current medical practice.

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If there are other areas in which you think that the Heart Association might suitably be of service, your comments will be welcome.

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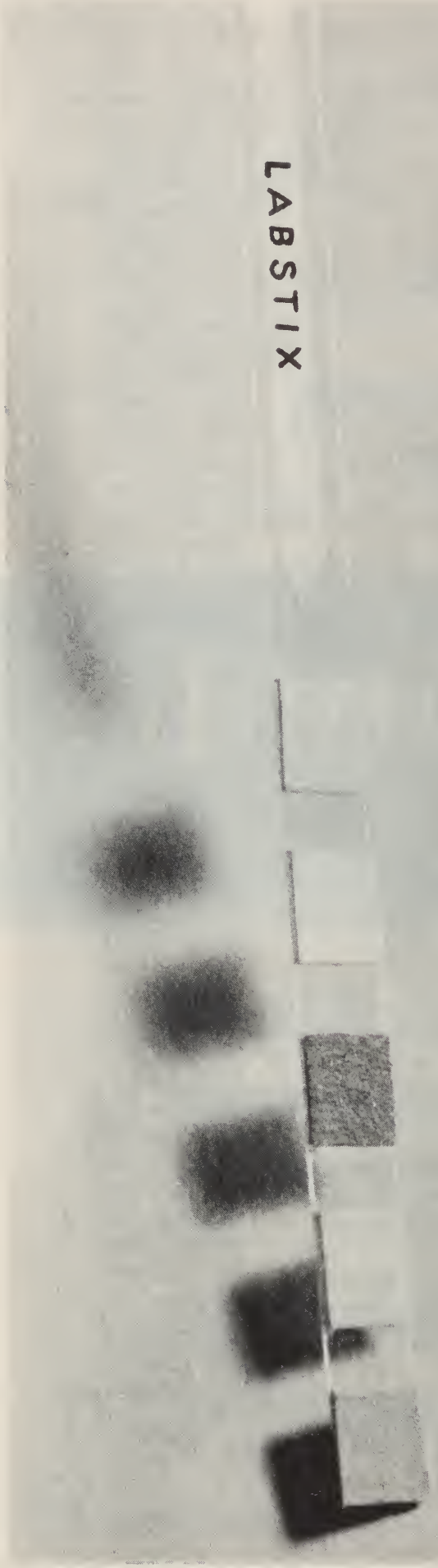
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MARYLAND RADIOLOGICAL SOCIETY
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RADIOLOGY FOR THE MEDICAL STUDENT

A Clinical Experience

JOHN M. DENNIS, MD
Professor and Head, Department of Radiology, University of Maryland School of Medicine

Medical education in the United States has been in a phase of transition since World War II, with many traditional teaching methods being replaced by radical new approaches. The undergraduate teaching of radiology has undergone many metamorphoses during this period. When one considers that today there is scarcely a human disease in which the science of radiology is not employed in its diagnosis or treatment and that the accuracy of radiologic diagnosis is exceeded only by microscopic examination of the disease tissue involved, there can be no argument that radiology should occupy an important position in the education of the medical student. Just what the student should be taught and how it should be taught is a matter of controversy and varies from almost nothing in some medical schools to a sizeable part of the curriculum in others.

Rigler has offered three fundamental objectives for a good undergraduate teaching program in radiology: 1) to produce good doctors by teaching students the maximum utilization of radiology in the care of their patients, 2) to elevate the status of radiology as a specialty, and 3) to obtain the best young physicians for residency and graduate training programs.

Every physician is charged with the responsibility of being a teacher, and the radiologist even more so when one considers the potential of radiology as a teaching discipline. That radiology is an ideal medium for dissemination of the basic science program is widely recognized, but it is in the clinical years that differences of opinion as to how much or how little should be taught become apparent. There are three basic concepts as to the amount of radiology that should be taught a medical student: 1) only that radiology exists and has certain usefulness in the diagnosis and treatment of disease, 2) the indications for the use of radiology, its possibilities, its limitations, and its dangers, and 3) as much radiology as possible, assuming that the more he knows about it the more he will appreciate its possibilities and limitations.

The status of radiology in American medical schools has suffered because many academic radiologists have accepted an excessive service function with neglect of their teaching and research responsibilities. Rapid increase in demands for more sophisticated time-consuming diagnostic radiologic studies have overtaxed the facilities and qualified professional personnel in many academic departments. Contact between the radiologists and students is infrequent, and the teaching functions of the radiologists have been assumed by members of other better staffed

clinical departments, tending to diminish the status of radiology among the medical specialties. In those areas where the radiologist does little teaching, the standing of radiology is low. Academic radiologists have an obligation and duty to develop in the minds of medical students during their formative years that radiology is best practiced by the radiologists.

As the youngest of the major medical specialties, radiology does not hold a high priority for time in the curriculum. Many schools are reluctant to make drastic curriculum changes, as many clinicians believe that radiology can best be taught as an integrated program closely related with other scientific disciplines and thus does not require a large separate block of time. The disparity between time given to anatomy and some other subjects and that given to radiology is deplorable when one considers the greater use made of radiology in clinical practice.

As a visual science, radiology is an excellent discipline in which to accentuate the teaching of anatomy, physiology, and pathology. Consequently, most American medical schools have a good integrated program of radiologic teaching in conjunction with these basic science departments. These same schools, however, offer the student little clinical training in radiology, particularly from radiologists, because of the excessive work load of the department and because other clinicians consider themselves to be excellent radiologists who can best instruct the student in radiology as an integral part of their clinics and conferences. This is not true. While some physicians, such as urologists and gastroenterologists, may be extremely capable radiologists in their own sphere of activity, they are not competent in all of the body systems. Medical students are taught that they must take care of the "whole patient," but in most instances, they are not being taught to do so from a radiologic standpoint. Even when radiologists are available at joint conferences to present and discuss the radiologic manifestations of a specific case or disease, this method of teaching is ineffectual for the undergraduate medical student. The student sees the particular findings demonstrated but is seldom put in the position of having to interpret or make a decision on these radiologic findings.

Because of the shortage of staff personnel, new teaching methods are being studied in some academic departments. Foremost of these is programmed teaching. While its superiority to more classical methods has not been proved, it is an effective method of teaching.

To provide good training in radiology for a medical student in his clinical years and to arouse his interest in it, it should be taught as a clinical subject the same as medicine, surgery, and obstetrics. The student must be given responsibility, when possible, for the radiologic evaluation of patients. To best meet this responsibility, the student should be assigned full time in radiology department for a period of time so that he can see radiology from the standpoint of the radiologist rather than as an observer at clinical conferences. Here, the student can be taught how to analyze the various radiologic studies and how to interpret the findings in making diagnoses. There should be a mandatory and an elective assignment in the department. This, of course, will require more professional personnel, and the medical schools must accept this additional financial responsibility.

For the past 10 years, we have been trying to make radiology a clinical experience for our third and fourth year medical students. On the basis of yearly student evaluation of the teaching in every clinical department, we think we have attained our goal reasonably well. A brief description of our program may be useful.

A series of 24 lecture-demonstrations is presented to the third year students, in small groups, covering the routine studies of the major body systems with a review of the normal anatomy and the commonly encountered lesions in each system. Five lectures on the basic principles of radiation therapy are also presented.

The fourth year students obtain clinical orientation in radiology. They have a scheduled assignment in the department, in groups of five or six, for a two-week period. During this time, on a rotational basis, the students 1) accompany the senior and resident staffs on fluoroscopy, 2) "walk the floor," interviewing and taking a history from all outpatients and then reviewing the radiographs with a staff radiologist, 3) observing, assisting with, and even performing special procedures, and 4) spending time in the

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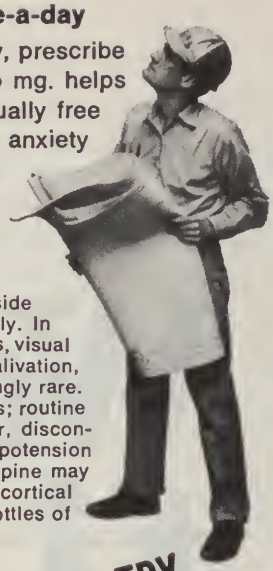
reading rooms with the staff radiologists going over the current cases, discussing the radiographic findings, and trying to correlate them with the clinical and expected gross pathologic findings. Daily noon time conferences are held with the students to review routine cases such as gastric ulcers, lung diseases, and heart disease. The students are also expected to review a student teaching file of select cases of the common disease entities in correlation with recommended reading assignments.

A one-month elective course in radiology offers fourth year students a more expanded program in clinical radiology. Since most of the students choosing an elective in radiology have already had the compulsory assignment, they are treated almost as first year residents. Under staff supervision, they are allowed to fluoroscope a few chests, interpret emergency room cases, and assist with and perform special procedures such as arteriography and lymphangiography. This elective has been popular with our students and has allowed us to screen the likely candidates for residency training. Several of our current residents became interested in radiology during their assigned or elective period in the department.

Undergraduate teaching in radiology should be a clinical experience for the student. Radiologists must wholeheartedly accept their responsibilities as teachers and impress on students that radiology is best practiced by radiologists. It should not be the aim that the end-product of a good educational experience in radiology be a neophyte radiologist, but a physician with a good understanding and appreciation of the role of radiology in clinical medicine.

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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Alcohol and the Cardiovascular System
A Survey of Some Recent Observations

EDWARD B. TRUITT, JR., PhD
Department of Pharmacology,
University of Maryland School of Medicine

The physician is often besieged by patients' ideas that alcohol has some beneficial effect on heart conditions. The most persistent idea is that alcohol may be a useful coronary dilator. Probably this belief arises from the fact that the analgesic effect of alcohol obtunds the pain of angina pectoris to a limited extent. The anti-anxiety effect of alcohol is a possible synergistic factor. Analogous reasoning may suggest that since alcohol dilates blood vessels in the skin it might be expected to do so in the heart.

These poorly founded concepts about the action of alcohol on the heart are difficult to lay to rest by even the best of repeated scientific experiments. All types of direct evidence have shown only a depressing action of alcohol on the contraction of heart muscle. In the Master 2-step exercise test, when the characteristic changes in the RS-T segments and T-waves of the electrocardiogram are used as an index of the oxygen supply to the heart, alcohol does not show the same beneficial action as nitroglycerin even though alcohol relieves the pain in anginal patients.[1] Direct measurements in situ on the exposed heart of coronary blood flow in dogs have also failed to show suitable increases in blood supply.[2]

Although it can be shown in isolated hearts that very high concentrations of alcohol (250-400 mg/100 ml) cause a slight increase in coronary blood flow, these results cannot be extrapolated to the intact heart, since the systemic pressure and hence the coronary perfusion pressure drop while the work of the heart is increased.[3] In another study it was found that this increased work by the heart occurs with even smaller amounts of alcohol than those required to lower the general blood pressure and that some of the dogs actually died from cardiac rather than respiratory failure.[4] The increase in heart rate during exercise is much greater after taking ethyl alcohol than during the same amount of work in a sober condition.[5]

The final picture of the effects of alcohol on the heart is seen on autopsy of heavy drinkers. There is an enlargement of the heart, an accumulation of fat, and other characteristic changes which are labeled by the pathologist as alcoholic cardiomyopathy.[6] These distinctive alterations are unrelated to nutritional status. Wendt,[7] in a preliminary report, ruled out the idea of vitamin or food deficiencies as the cause by placing alcoholics on an adequate diet with a high level of vitamin supplements. He believes that heart changes can be detected earlier than the appearance of such obvious symptoms as x-ray or ECG changes by measuring changes in two enzymes, aldolase and lactic dehydrogenase. These and other enzymes are not normally released by the heart at rest or during light exercise, and their appear-


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ance in the serum of alcoholics suggests a metabolic derangement of the heart cells.

Ferrans et al[6] observed damage in the heart cells to the mitochondrial particles which contain these enzymes and are responsible for most of the energy supply of the cell. This mitochondrial damage may be the fundamental lesion in alcoholism. Previous work in this department has shown that acetaldehyde produced in the oxidation of alcohol has a potent inhibitory effect on mitochondrial energy mechanisms while ethanol is ineffective directly even in fatal concentrations.[8] A more recent study, still under way, indicates that many alcoholics develop higher blood levels of acetaldehyde than more moderate drinkers.[9]

All of these studies point to the inevitable conclusion that alcohol is just not good for the heart in any measurable way. It seems possible that in certain persons in whom emotional causes of high blood pressure are relieved by small doses of alcohol that a limited amount might be beneficial. Certain other circulatory disorders, such as Buerger's disease and other arterial spasms, might be helped, but better drugs are available for all of these conditions. A dose of brandy has a time-honored place as a reflex stimulant to the circulation, but in general it is difficult to establish a worthwhile case for rational use of alcohol on the circulation.

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Childhood Asthma and Mental Retardation

IDRIS M. GRIFFITH, MD

The incidence of childhood asthma was investigated in a series of 400 consecutive outpatients seen at the Children's Psychiatric Research Institute, London, Ont., between January 1961 and January 1962. Of this number 380 were mentally retarded and 20 were of normal intelligence. Health histories for each child were obtained in the following ways: (1) A questionnaire was filled in at home by the parents before coming to the clinic. (2) A full health history of the child was obtained by the attending physician during the first day-long session and this was supplemented by a session with the social worker. (3) Further information about the child and the family was obtained by the doctor and social worker during the four or five sessions that took place in the ensuing six months. The incidence of asthma among the parents was also ascertained; the finding was later double-checked over the telephone by the author and by a voluntary worker in contact with the parents and the doctor concerned.

RESULTS AND COMMENT

Of our 400 children, two were reported to have chronic asthma. One of these had an intelligence quotient of 108 and the other of 78. This places them both above the mental retardation level. Of the 380 mentally retarded children not one gave a history of asthma.

In school children in Birmingham, England, Smith[1] found an overall prevalence of asthma of 1.76 per 100 persons. On this basis we expected six or seven cases among our 400 patients. The approximately 800 parents, however, contained 11 with asthma, which is near the average for the general population.

DISCUSSION

Our cases of mental retardation have such varied etiologies that it is not possible to generalize to the effect that there is a negative relationship between mental retardation and childhood asthma. Guthrie,[2] for example, has reported a phenylketonuric child with asthma.

It is generally recognized that psychodynamic factors often play a role in the onset of childhood asthma. It may be that the brain-damaged or mentally retarded child is unable to partake in certain types or degrees of emotional interaction between parent and child seen in the normal child. In a strictly physical approach one may entertain hypotheses concerning possible cortical cell deficiencies or biochemical abnormalities.

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MARYLAND POISON INFORMATION CENTER

The Maryland Poison Information Center has been established as a 24-hour, seven-day a week service for Maryland physicians. It is sponsored by the Maryland State Health Department with the financial aid of a beneficient organization.

The growing variety of medications and toxic commercial products and the rapid developments in clinical toxicology has created the need for a central agency with a comprehensive up-to-date library and a staff trained to quickly locate product composition and toxicologic data. It is to supplement the present eight Poison Control Centers:

1) Baltimore City Hospitals
2) Johns Hopkins Hospital
3) Peninsula General Hospital
4) Sacred Heart Hospital
5) Sinai Medical Institutions
6) Suburban Hospital
7) University of Maryland Hospital
8) Washington County Hospital

These were initially sponsored jointly in 1956 by the Maryland Chapter of American Academy of Pediatrics and the State Department of Health and will continue to function especially as treatment centers.

Incoming calls are taken by the medical secretary or one of the pharmacists who have been intensively trained in the past six months to handle requests for technical information. Should the inquiring physician wish medical consultation, physicians experienced in current clinical toxicology are always on call.

The aims of the Center are to give more individualized and improved patient care and to stimulate future toxicologic research through up-to-date and easily accessible information for physicians. It is also hoped through data collection to increase recognition of etiologic situations and stimulate more prevention programs for the public.

In suspected cases of poisoning call DI 2-0800 for the following information:

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Highlights of Sanitary Services for 1965

ENVIRONMENTAL HYGIENE

The Division of Community Sanitation serviced 2,750 complaints concerned with various insanitary conditions and nuisances. Inspections of foster homes, day nurseries, hospitals, the city water supply, and swimming pools were continued. Over the last six years, the number of pools to be regularly inspected has more than doubled to a total of 73.

The Division of Rodent Control serviced 3,015 complaints of rodent infestation, investigated 69 rat bite cases, and took corrective action where necessary. Cooperation continued with the Urban Renewal and Housing Agency and neighborhood councils in developing rodent control programs in specific areas. In addition, programs of rodent and insect control training were given by the division to the Fort Howard Veterans Hospital personnel, to Health Department personnel of both Baltimore and Frederick counties, and to personnel of the city's Bureau of Building Inspection.

FOOD CONTROL

In 1965, the Bureau of Food Control made 13,000 inspections of the 33 types of food establishments in the city and investigated 800 complaints. A total of 180,000 pounds of food was condemned.

Alleged food poisoning outbreaks decreased from 29 in 1964 to 24 in 1965, and only four were proved to be foodborne. The food industry continued to supplement the work of the bureau inspectors with its self-inspection program.

Three potentially dangerous imported novelties were removed from sale in stores. These were stuffed baby ducks containing both a pesticide and salmonella organisms, highly explosive candy-like "cracker balls," and "ice kools," plastic drink coolers that were found to contain polluted water.

INDUSTRIAL HYGIENE

The Baltimore Metropolitan Air Quality Survey was begun as an official project of the Baltimore City Health Department, the Maryland State Department of Health, and the Baltimore and Anne Arundel County health departments. This air survey group selected and ordered the equipment for monitoring pollutants at six stations of the Metropolitan Air Quality Network.

In striving to improve air quality in the city, a cooperative agreement was reached with the Baltimore City Fire Department on the issuance of permits for open burning.

The bureau continued its measurement of fallout radiation in the air and the city's water supply. In addition, 13 veterinary x-ray units were surveyed. Four were found to conform to state requirements, and nine were required to take corrective action.

No child deaths from lead paint poisoning occurred in the city in 1965. This is the first year in which there was no death from this illness since 1931, when records of lead poisoning were begun. Child lead paint poisoning cases dropped to 32, the lowest in 10 years.

MEAT INSPECTION

The Bureau of Meat Inspection personnel supervised the processing of 27,000,000 pounds of meat and meat products in both city and county

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processing plants and condemned 797 pounds. Of the 203,000 livestock slaughtered, only 251 whole animals and 25,000 animal parts were condemned as unfit for human consumption. On one occasion 100,000 pounds of meat suspected of spoilage was held for reexamination; however, all but 10,000 pounds was approved on reinspection.

The bureau also conducted rabies examinations in connection with 975 dog bite cases in 1965. These were made in cooperation with the City Health Department's Bureau of Communicable Diseases and the Municipal Animal Shelter.

MILK CONTROL

The problem of pesticides in milk was brought under control in 1965. During the year only two farms were suspended for unacceptable pesticide levels in their milk, and they were reinstated when the condition was corrected. In 1965, for the first time, all farms had converted from storing and transporting milk in cans to storing in refrigerated bulk tanks and transporting in tank trucks to the milk plants.

The milk industry continued its self-inspection system with monthly milk samples tested at certified industrial laboratories and the results reported to the City Health Department.

For the 10th consecutive year no instance of improper pasteurization of milk was reported.

Cooperation continued with the U. S. Public Health Service and the Maryland State Department of Health in testing for radioactive fallout materials in milk. No unsafe levels were discovered.

Robert E. Farber, MD
Commissioner of Health

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

Highlights

TITLE XVIII CONTRACT SIGNED

In a contract signed between the State of Maryland and the Social Security Administration, Governor Tawes designated the Health Department as the state agency to work with the Social Security Administration on Title XVIII of Public Law 89-97. This section of the Act, which concerns the hospital insurance program for all persons over 65, requires certification of providers of supplemental medical benefits, such as hospitals, extended care facilities, home health agencies, and independent laboratories. As the agency responsible for certification, the Department will verify eligibility of such providers to participate in the new Social Security program and will give assistance and consultation to help any who may not qualify.

PROCESSING MEDICAL BILLS

An increasing backlog of Medical Care bills made it necessary last fall to initiate a regular four-hour night shift on the accounting machines. This has increased the average number of bills processed by almost 40%. The number of bills exceeds 100,000 each month. This interim step to keep bills up to date will be continued until the new computer is installed.

MALARIA CASE CONFIRMED

The alertness of a private laboratory technician in identifying the parasite **Plasmodium malariae** brought about the quick diagnosis of the relatively rare Quartan type of malaria. The patient, an adult man, had returned to Maryland in November, 1965, after eight months in Liberia. The diagnosis was confirmed by the State Health Department laboratories, which then referred the blood specimen to the Communicable Disease Center in Atlanta.

RABIES IMMUNIZATION PROGRAM

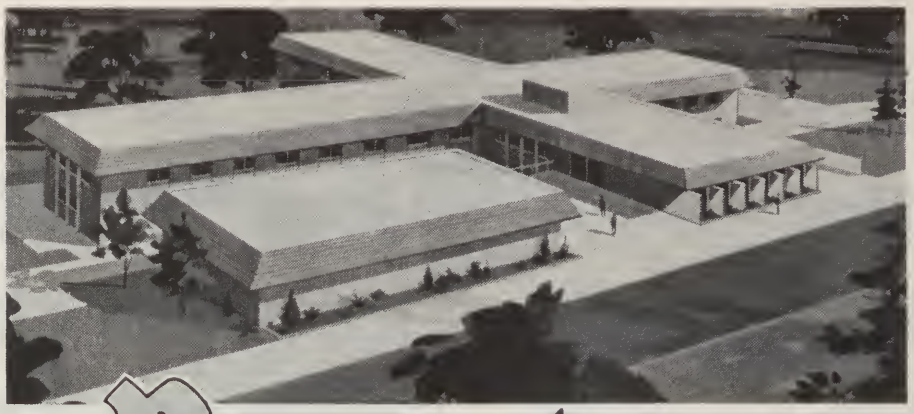
After the Health Department recommended vaccination of high-risk groups against rabies, services were requested by the State Department of Game and Inland Fish and the Maryland State Veterinary Medical Association.

The program developed by the public health veterinarian is twofold: 1) It offers protection, without the risk of horse serum, to people who are frequenly exposed to biting animals which may be rabid. 2) When these people have become immunized, they may donate blood which can be used to make a safer product for treating others who have been bitten by animals.

NEW PUBLIC HEALTH NURSING CHIEF

Mrs. Ruth B. Marggraff, RN, MPH, has been appointed chief, Division of Public Health Nursing, succeeding Miss Helen L. Fisk, who retired in December after 23 years of service with the Health Department.

Mrs. Marggraff formerly was director of public health nursing for the Anne Arundel County Health Department. The division which she now heads assists local health departments in developing nursing services, maintaining standards, recruiting and train-



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ing new personnel, and offering in-service nursing education. It also cooperates with program directors in initiating programs and services.

Mrs. Marggraff graduated from the San Diego County General Hospital School of Nursing and was supervisor in the hospital's obstetrical department for a year and a half. She received her BS in nursing from the Catholic University of America and her MPH from the University of Pittsburgh. Her 26-year career includes experience as a staff nurse in the Visiting Nurse Association and as a nurse-audiometrist in the Waterbury, Conn., Health Department. She was an instructor in the American Red Cross Nurse's Aide Corps during World War II. In 1965, Mrs. Marggraff was cited as outstanding woman of the year by the Business and Professional Women's Club of Maryland.

She is the widow of Commander Frederick C. Marggraff, Jr., who was stationed at the Naval Engineering Experiment Station in Annapolis during World War II.

STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

A Midyear Report

A total of 16,287 patients was treated in Maryland's psychiatric hospitals during the first six months of the 1966 fiscal year. The increase of 2,051, or 14.4%, during the past four years represents a continuation of a long range upward trend. Proportionally, it exceeds the increase in Maryland's total population during this period.

This steady growth has been due mainly to the rapid patient turnover resulting from the growing number of admissions for short term intensive treatment for acute disturbances. As indicated in the table, both admissions and discharges increased substantially between 1962 and 1966. At the same time, the average size of the hospital population has remained virtually unchanged.

Most newly admitted patients are released within three months, and nine out of 10 leave within one year. Only 5% remain hospitalized after two years. This has meant that there is now only a moderate buildup in the number of patients hospitalized continuously for extended periods. As former long term patients die or are released, they are replaced by a smaller number of new chronic cases. The net effect of this has been that:

1. The proportion of beds occupied by long term patients with chronic illnesses is decreasing while the proportion occupied by short term patients with acute disturbances is rising.

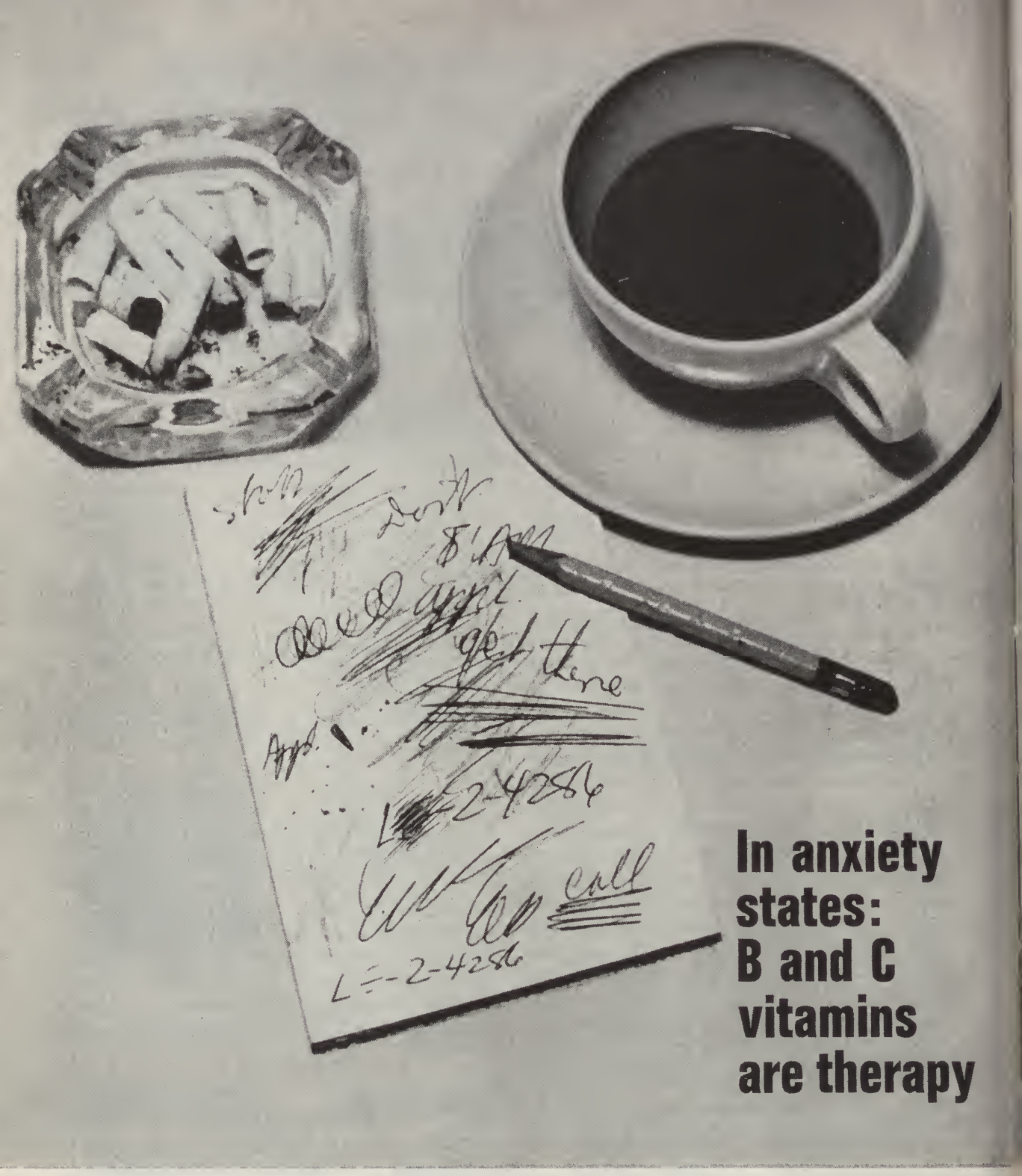
2. The average period of hospitalization of newly admitted patients is going down and is now much smaller than a few years ago. At the same time, the proportion of released patients who are rehospitalized does not appear to have changed.

3. The average size of the hospital population has remained unchanged at the same time that the total number of patients treated is increasing. However, due to the rise in the number of admissions, it too is now beginning to go up.

The implications are important: One, the development of community centered programs has not yet reached the admissions to state hospitals. Further, expansion and coordination of alternatives to hospitalization in a state operated facility is therefore essential. It should be clear also that patient-staff ratios applicable to a custodial hospital population are not applicable to a patient population experiencing a rapid turnover. Continuing reevaluation and reassessment of needs is indicated if adequate service levels are to be maintained.

Kurt Gorwitz

First Six Months of Fiscal Year	Average Size of Hospital Population	Total Patients Treated	Admissions	Discharges
1962	8,297	14,236	2,877	2,443
1966	8,093	16,287	4,420	3,784
Net change	—204	+ 2,051	+1,543	+1,341
Per cent change	— 2.5	+14.4	+53.6	+54.9



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Professional Business Management

Office Tidiness—A Continuous Chore

This article originally appeared in Physician's Management, *October, 1962. It was presented as a fall office cleaning idea. We now present it as a suggestion for spring office cleaning.*

WILBURN L. McCLURE, Jr.

When's the last time you thoroughly cleaned the office and cleared out the excess baggage? While everyone knows that keeping the office neat is a daily problem, a more thorough effort should be made at least once a year. You should set aside a time each year to be sure this is done in as orderly and least harassing method as possible.

Have you innocently opened the closet next to the examining room recently and a box of miscellania cascaded down from the top shelf? If so, you have probably reached a critical state in your twentieth-century American life; the stage when you simply own too much.

The squeeze doesn't usually start until after several years of practice. Then it moves inexorably toward a climax. Here are some simple tests.

Can you walk across your reception room without noticing an excess of magazines, crooked pictures, or dusty window sills?

Have you permitted extra umbrellas, coats, and hangers to accumulate in the waiting room closet or the one you and your aides use?

Does your drug room or storage closet look like an oversized, disorganized, overstocked household medicine cabinet?

Is there a heap of medical journals, miscellaneous junk mail, and the like in the office?

There are more questions, but if your answers are unfavorable so far, it is time to employ a few remedies to solve this problem.

There is only one real cure: clear out the unneeded items and clean up your office. Sift through that accumulation of clutter for what you really need. The best way is to pretend you are going to move and have to pack everything in cartons for the truckers. Place one big carton in the center of each room, top open. By the time you have dragged out the nearly empty tissue boxes, irreparably broken instruments, outdated drug samples, old magazines, and so on, you should have developed sufficient despair to do a good job of chucking things into the cartons.

Once the cartons are filled, have the janitor pick them up immediately and haul away. Do not, by any means, give in to the temptation to hold them in the office "just overnight." If you allow them to remain, odds are that half the stuff will be right back where it came from in the morning.

George Bernard Shaw said, "The more a man possesses, the more careworn he becomes." How true!

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MARCH, 1966

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

FASHION FIREWORKS GO OFF WITH A Bang



The eleventh annual luncheon and fashion show of the Woman's Auxiliary to the Montgomery County Medical Society, held at the Regency Ballroom of the Shoreham Hotel on November 2, earned more than $1,800 for the auxiliary's scholarship funds for medical and nursing students.

Carrying out the theme of "Fashion Fireworks," red fire crackers adorned the tables, and a large red rocket dominated the center of an x-shaped runway. Fashions illustrated "Rockets Red Glare," "Sports Explosion," "Shoot the Moon," and "Flares in the Night."

Left to right: **Jackson Weaver, of Radio Station WMAL; Mrs. James A. Roberts, president of the Woman's Auxiliary to the Montgomery County Medical Society; Mrs. Richard E. Lukes, luncheon chairman and president-elect; and Frank Harden, of Radio Station WMAL.**

In the grand finale, the models carried sparklers.

The fashion show was staged by couturier fashions from the Embassy Room of the Hecht Company and featured American and European designs. An ensemble by Sidney furnished music, and Frank Harden and Jackson Weaver of Radio Station WMAL were masters of ceremonies.

Awards were presented to Dr. William B. Walsh, founder and president of Project HOPE, and Dr. Nicholas P. Dallis, creator of the comic strip, "Rex Morgan, MD." Philip Steitz, associate director of the Volunteers in Service to America, former managing editor of the newspaper syndicate for the "Rex Morgan, MD" comic strip, accepted the award for Dr. Dallis. The certificate cited Dr. Dallis' "laudable and noteworthy contribution over the years to the field of medicine, to its improved understanding by the laiety and toward enhancement of the public image of the physician."

Dr. Walsh was recognized for his "noteworthy contribution to humanity through the promotion of international medicine, cooperation, understanding, good will and improved health standards."

Honored guests included John P. Haberlin, MD, president of the Montgomery County Medical Society; Mrs. Martin E. Strobel, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland; Mrs. Hugh O. Fulcher, president of the Woman's Auxiliary of the District of Columbia; Mrs. William H. Stewart, wife of the Surgeon General of the United States; Mrs. Luther L. Terry, wife of the former Surgeon General of the United States; the Reverend John O. Humbert, pastor, North Chevy Chase Christian Church, and Mrs. William B. Walsh.

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BONE TUMORS, 3rd ed, by Louis Lichtenstein, MD. Mosby, 1965. $16.75

As with the preceding editions, this is offered primarily to supply the practical answers needed by the pathologist, the surgeon, or the radiotherapist interested in bone tumors. Many observations made since 1958 have been incorporated in this text, and the entire edition has been considerably revised.

VISUAL CAPABILITIES IN THE SPACE ENVIRONMENT, edited by Charles A. Baker. Pergamon Press, 1965. $10.50

This is a compilation of up-to-date information on the capabilities and limitations of man's visual sense in the exploration of space. Sixteen articles, by twenty contributors, cover vigilance and the visual environment in space and the effects of vibration on vision. Specific mission problems are dealt with, such as visual aspects in lunar landing, and visual reconnaissance from space. One article summarizes the visual experiences of previous astronauts and cosmonauts, and another suggests visual experiments for future space flights. The new concepts on human vigilance presented here by Dr. Jerison and Dr. Pickett have heretofore not been published.

PROGRESS IN THE CHEMISTRY OF FATS AND OTHER LIPIDS, volume VIII, part 1, edited by R. T. Holman. Pergamon Press, 1965. $15

This volume is the latest in a series designed to fill a serious gap in the literature of a field in which there is rapid expansion. Part One contains a comprehensive article by Van Deenen entitled "Phospholipids and Biomembranes."

PHARMACOLOGY OF THE CORONARY CIRCULATION, by N. V. Kaverina. Pergamon Press, 1965. $12.50

This book deals with an important problem in contemporary medicine—pharmacologic action on the coronary circulation. The present state of the problem is reviewed, and the author's research is described. He considers methods and approaches to the study of coronary circulation, its physiology and mechanisms of pharmacologic effects. Drugs influencing the nervous control of coronary vessels are discussed at some length. New evidence is offered on the mechanism of action of some pharmacologic agents; the diphasic action of epinephrine on coronary vessels is described.

ATLAS OF CATARACT SURGERY, by John M. McLean, MD. Mosby, 1965. $20

This book is intended as a practical instructive manual for the operating surgeon. An outgrowth of more than 25 years of teaching and lecturing, it illustrates in detail those methods which have proved most practical.

THE ECONOMICS OF VOCATIONAL REHABILITATION, by Ronald W. Conley. The Johns Hopkins Press, 1965. $6

This study deals with economic problems caused by physical and mental disability and the economic feasibility of rehabilitating mentally and physically handicapped persons. The author, an economist at the National Institute of Mental Health, maintains that the costs of rehabilitation are less than the increased financial value of the rehabilitated person to the economy. He supports his belief that rehabilitation programs not only benefit the disabled person but also are a sound investment for businessmen and taxpayers.

PEDIATRIC ELECTROCARDIOGRAPHY, by Warren G. Guntheroth, MD. Saunders, 1965. $7

This monograph introduces a pediatric approach to electrocardiography. The discussion was kept simple and short to induce the reader to progress from the beginning to the end of the book, since the parts are interdependent. Illustrations are those of the author.

DOCTORS AND THE STATE, by Jeanne L. Brand, PhD. The Johns Hopkins Press, 1965. $7.95

This study traces the role of the British medical profession in the development of government action for preventive and curative medicine during the transition years, 1870-1912, which led England toward a program of socialized medicine. Based on broad research in many hitherto unpublished official sources, the book opens with the work of the Royal Sanitary Commission and the establishment, in 1871, of a new central authority for public health and concludes with the battle between Lloyd George and the British Medical Association during the passage of the National Health Insurance Act of 1911.

The author also describes the significant part played by medical men individually and by medical journals in the passage of comprehensive sanitary legislation, as well as many other aspects of the changing patterns of state medicine in Britain.

MANAGEMENT OF THE PATIENT WITH CANCER, edited by Thomas F. Nealon, Jr., MD. Saunders, 1965. $27.50

Seventy-one authorities covering every aspect of the treatment of cancer have contributed to this massive volume. It is a comprehensive work designed for general practitioners and specialists in medicine and surgery who treat patients with neoplasms. It brings to them the essential information about cancer of all sites in a succinct manner so that they can appreciate the best approach to the management of each patient.

The contributors have attempted to be particularly specific about manifestations of the disease, methods of diagnosis and criteria for proof of diagnosis, selection of form of treatment depending upon the extent of the disease, results that may be expected from treatment, likely manifestations of recurrence, and the latest methods of palliation for recurrent cancer.

Each contributor was asked to describe a rational plan of management of a particular problem and to omit exhaustive cataloging of alternative methods. When a well known or popular procedure is not recommended, the author explains his reason for not supporting it.

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MEDIC programs may also be heard at headquarters of the following cooperating organizations: the Medical and Chirurgical Faculty of the State of Maryland, the Maryland State Department of Health, the Hospital Council of Maryland, Inc.

The Johns Hopkins Hospital presents Pediatric Grand Rounds from 8-9:30 AM and Medical Grand Rounds from 10-11:30 AM every Saturday. These programs may be heard only at the participating hospitals of the MEDIC network.

Appropriate AAGP credit is given for every MEDIC program attended, including Grand Rounds.

See Page 7 for current program listings.

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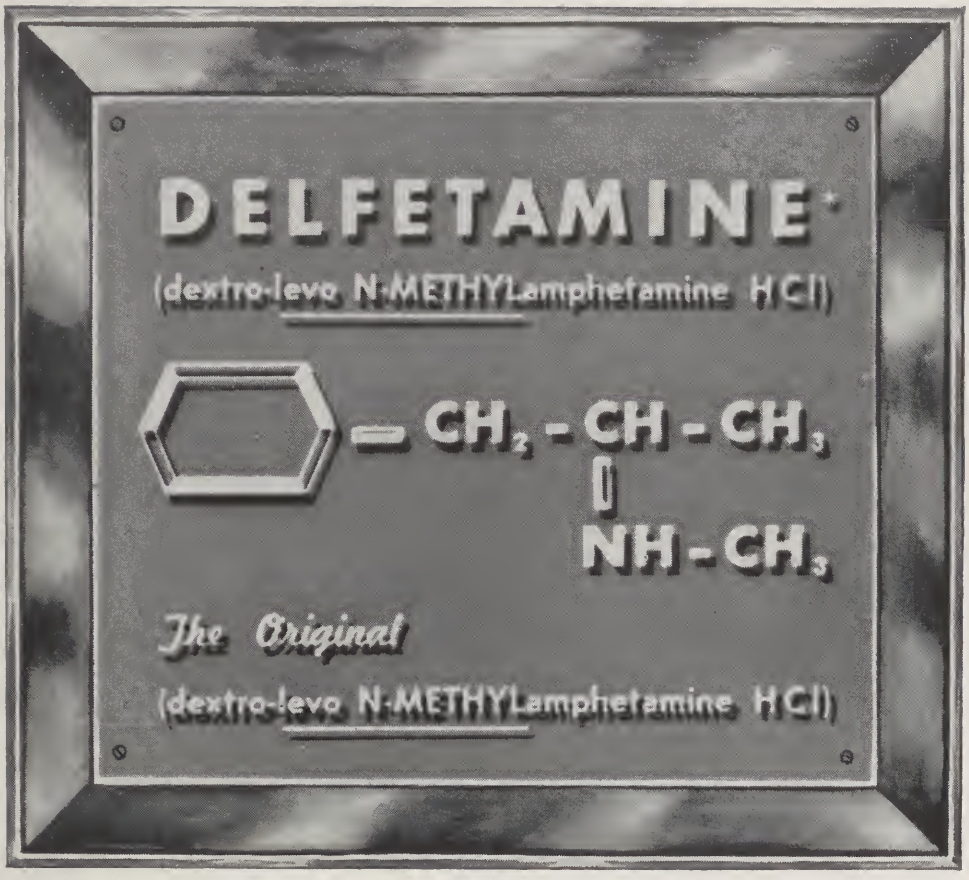
Southern District
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Arthur Wooddy, MD—1968

South Central District
Austin B. Rohrbaugh, Jr., MD—1966
Richard D. Bauer, MD—1967
Terms of office expire at conclusion of annual meeting

DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION
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J. Sheldon Eastland, MD—1967
Robert vL. Campbell, MD—1968

ALTERNATES:
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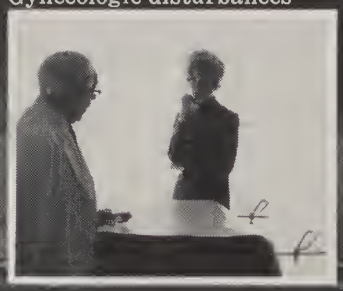
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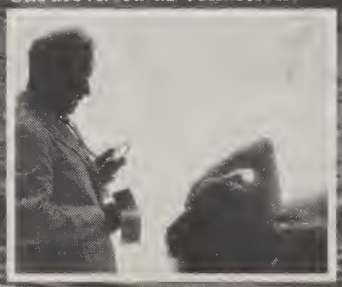
Gynecologic disturbances



Environmental stress



Cardiovascular conditions



Vol. 15 No. 4
April, 1966

Maryland
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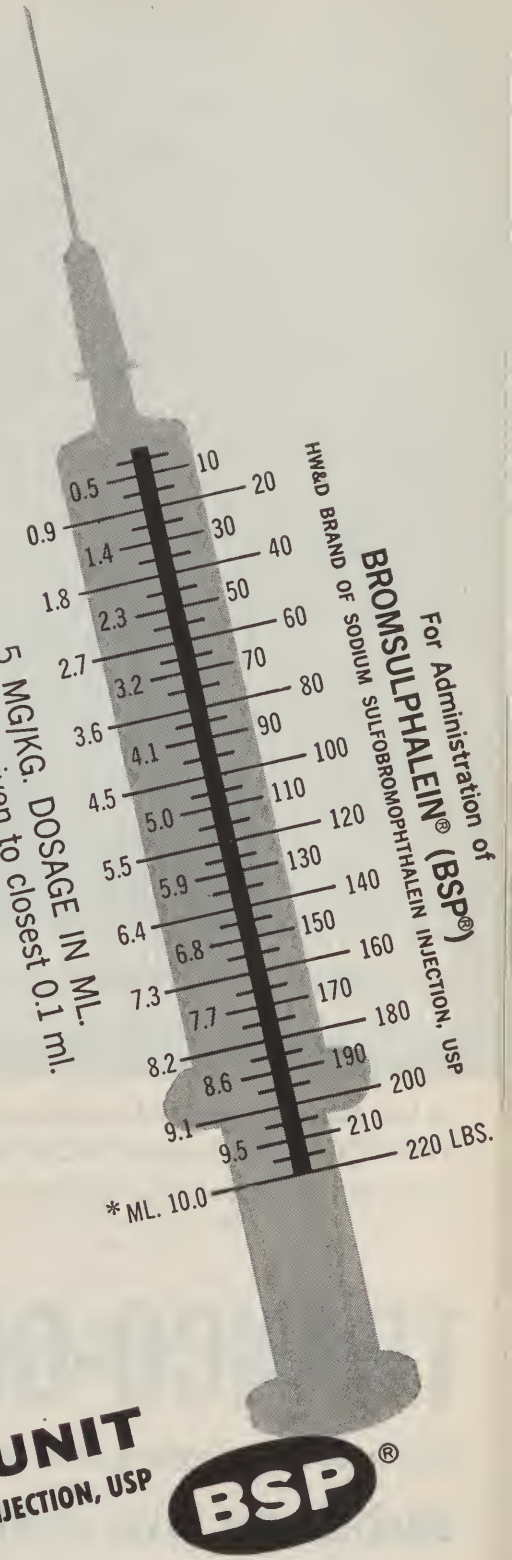
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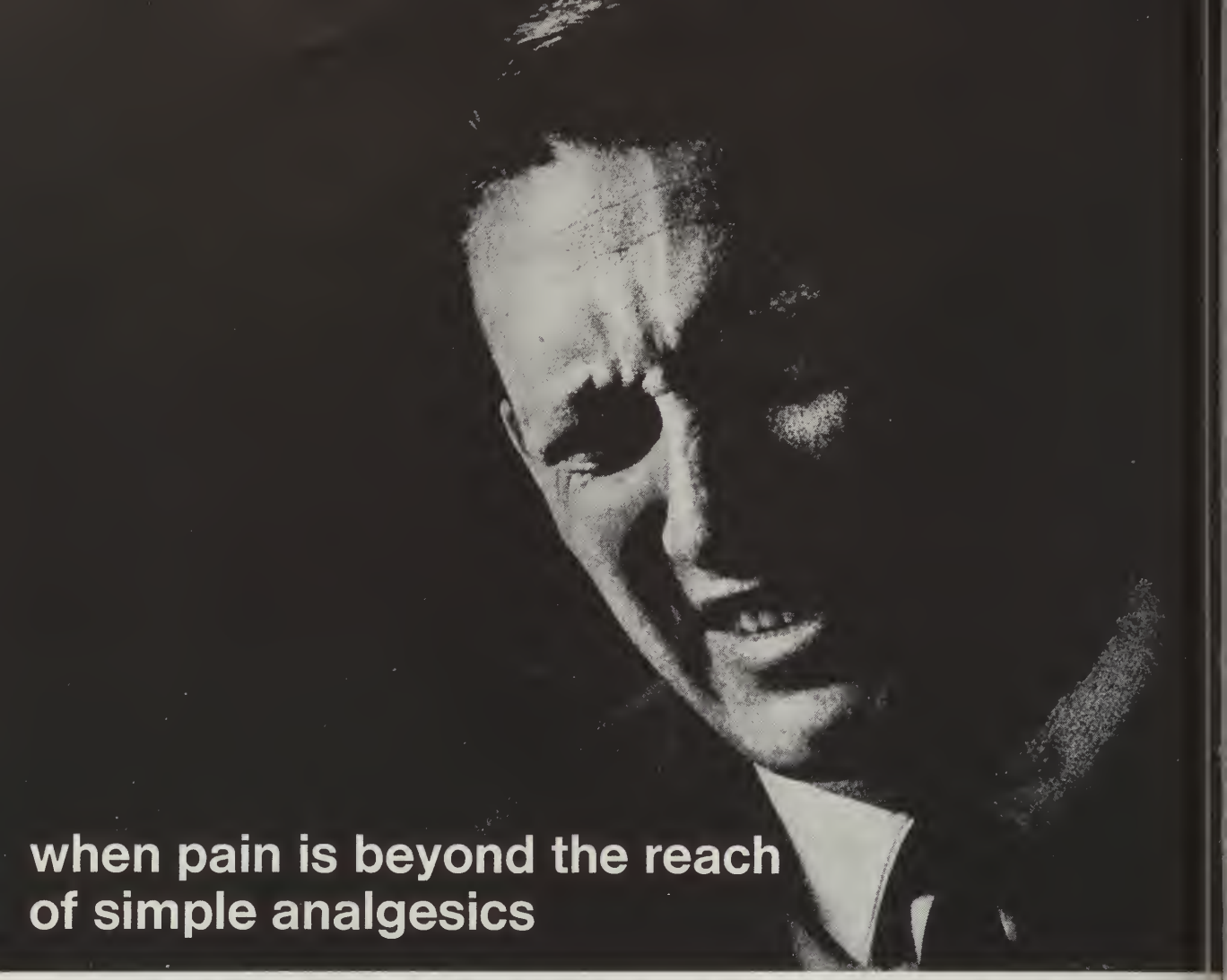
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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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Maryland
STATE MEDICAL JOURNAL

Vol. 15, No. 4
April, 1966

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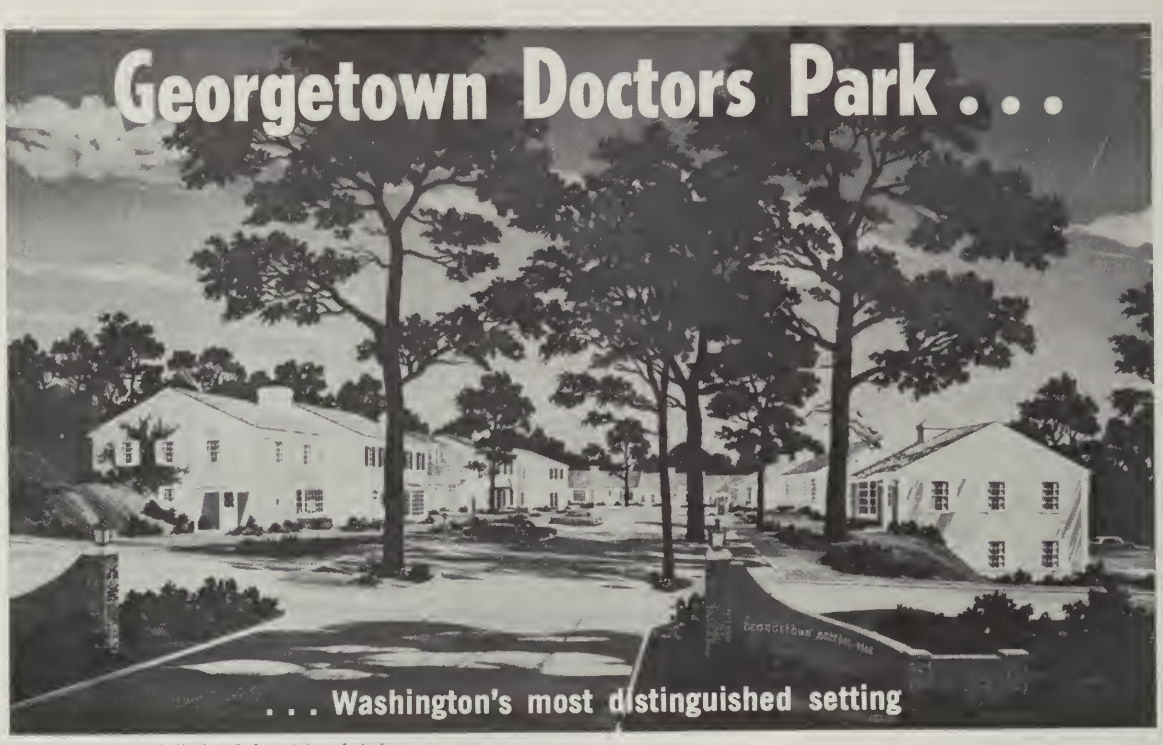
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April 27-Moy 4, 1966—Annuol meeting, Medicol ond Chirurgicol Faculty of the Stote of Moryland.
April 27-28, Boltimore—April 29-Moy 4, Aboard ship and in Bermuda
See program Pages 66-67

MEDIC PROGRAMS

April 22—1-2 PM

From Frederick Memorial Hospitol: "Leukemia," Edword S. Henderson, MD.

Moy 6—12:30-1:30 PM

From University Hospital: "Problems of Obscure Fevers," Theodore E. Woodword, MD, ond Richard B. Hornick, MD.

May 13—12:30-1:30 PM

From The Johns Hopkins Hospitol: "Diabetes of the Elderly," Reuben Andres, MD.

May 27—1-2 PM

From Frederick Memariol Hospitol: "Blood Transfusions," Julius R. Krevans, MD.

You moy heor these programs in the Foculty ouditorium or ot one of the porticipoting hospitals (see Page 140).

AMERICAN PSYCHIATRIC ASSOCIATION

April 21-22—Psychiatric Institute, University of Morylond School of Medicine
Regional conference on "Psychiatric Epidemiology and Mental Health Planning.

HEART ASSOCIATION OF MARYLAND

Moy 3-4—Baltimore City Hospitals

Nursing seminar on "A Stroke Clinic for Practical Nurses."

MARYLAND NOSE AND THROAT SOCIETY

May 9—Sheroton Belvedere Hotel, Baltimore

7:30 PM—Dinner meeting. "Treotment of Tumors of the Heod ond Neck in Children," John J. Conley, MD, New York.

MEDICAL SOCIETY OF NEW JERSEY

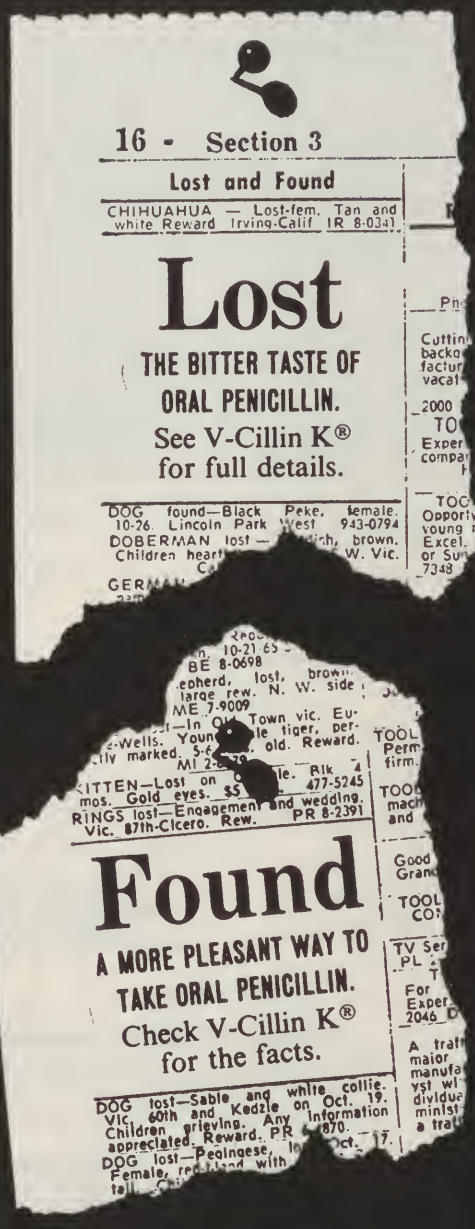
May 14-18—Haddon Holl, Atlontic City

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MARYLAND ACADEMY OF GENERAL PRACTICE

May 21-22—Woshington Hilton Hotel, Woshington, D.C.

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April, 1966

Editorial

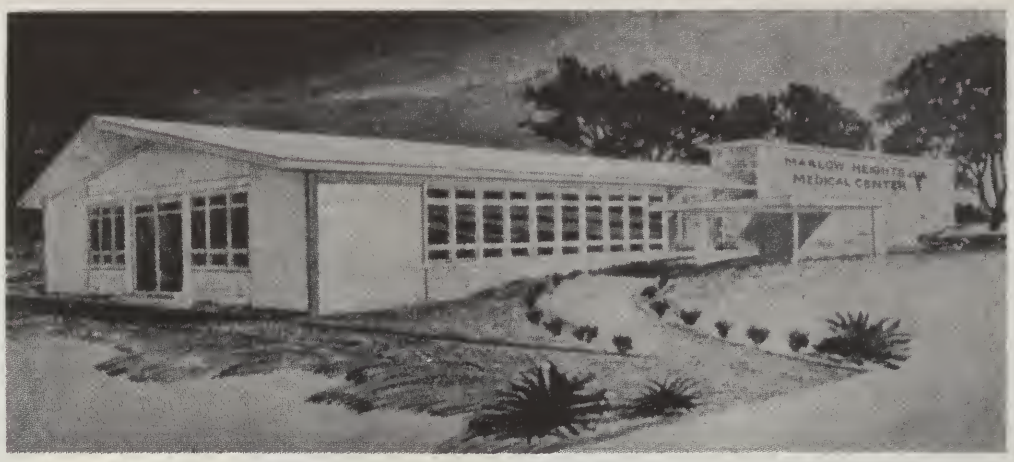
Professional Disciplinary Proceedings: What Constitutes Professional Misconduct

In three recent decisions the Appellate Division has unanimously given judicial sanction to administrative discipline meted out to three professionals: a pharmacist, a doctor, and a lawyer. For purposes of discussion it is not necessary to reveal the names of the individuals involved. Nevertheless, it is interesting to note the harshness of the discipline imposed, the revocation of the license to practice, and the reasons for the imposition of such a harsh penalty.

In the case of the pharmacist the Appellate Division for the Third Judicial Department found that he had been guilty of unprofessional conduct and refused to review a determination by the Board of Regents which had revoked his license. The pharmacist admitted that he did not make an inventory of the narcotics on hand in the hospital pharmacy when he ended his employment and that he destroyed certain inventory cards containing records of drugs dispensed to patients. The Court found that "[t]he uncontroverted proof in this record is sufficient to sustain the board's determination of unprofessional conduct. . . . It would be more difficult to conceive of actions more unprofessional than that of this pharmacist and his conduct in the hospital." [App. Div. 24 2d 694, 261 N. Y. Supp. 2d 410, 412 (3rd Dept., 1965)] The Court relied upon a regulation which provides that a pharmacist is guilty of unprofessional conduct in ". . . [w]illfully or knowlingly violating any Federal, State, or local law, regulation, or rule designed to protect public health by controlling the manufacturing, distributing, selling or dispensing of drugs and/or narcotics." [24 App. Div. 2d 694, 261 N. Y. Supp. 2d 410, 411 (3rd Dept., 1965)]

The doctor in question had been convicted upon his plea of guilty to a violation of a Federal statute in that he had tried corruptly to influence the due administration of justice. The crime was a felony under Federal law, but was only a misdemeanor under New York State law. For conviction of a misdemeanor professional discipline is permissive. The doctor was charged with unprofessional conduct and in a disciplinary proceeding his license was revoked. The doctor contended that the supposed unprofessional conduct for which discipline was imposed were unconnected with medical practice. Despite this contention, the Appellate Division for the Third Judicial Department approved the license revocation stating: ". . . unprofessional conduct on the part of a physician is not limited to acts directly relating to his treatment of patients. . . . [i]n our opinion the acts committed by the respondent were so heinous and wrongful as to negate the contention that respondent possesses the high degree of good character which is expected and

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required of a member of the medical profession. The public has the right to expect from the members of the medical profession the highest degree of integrity. We find respondent's conduct was so reprehensive as to indicate that he does not possess such integrity and that such conduct reflects most unfavorably on the medical profession." [24 App. Div. 2d 698, 699, 261 N. Y. Supp. 2d 634, 635 (3rd Dept., 1965)]

Finally, the attorney refused to honor a *subpoena duces tecum* requiring him to produce his financial records and testify before a judicial inquiry investigating his conduct and practices as a lawyer. The attorney refused to do so on the grounds that his records and his testimony would tend to incriminate him and he was entitled to rely on the State and Federal constitutional provisions protecting him against self incrimination. The Appellate Division for the Second Judicial Department disbarred the attorney stating: "Our view, as previously stated, is that a lawyer, like any other citizen, has an absolute right to invoke his constitutional privilege against self incrimination and to refuse to supply the pertinent information; but that when a lawyer does so he fails in his inherent duty to the Court to divulge all pertinent information necessary to show his character and fitness to remain a member of the Bar and necessary to the proper administration of justice, and he must, consequently, forfeit his privilege of remaining a member of the Bar. . . . If he elects to invoke his constitutional privilege of self incrimination and thus avoid exposure to criminal prosecution—an election which undoubtedly is his to make—he cannot at the same time retain his privilege of membership in the Bar." [24 App. Div. 2d 653, 654 N. Y. Supp. 2d (2d Dept., 1965)]

From these decisions it is apparent that the courts sanction and impose severe penalties upon the conduct of professional men. Indeed, professional men as a class are examined for character and moral fitness before being licensed. Whenever their actions reflect adversely on their own character or moral fitness the courts may approve the harsh sanction of license revocation. Indeed, the courts seem to indicate that to retain his license a professional man may have to forego some of his most important and hallowed constitutional rights.

Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

COUNCIL, JANUARY 27

1. The Subcommittee on Alcoholism presented several recommendations, which were approved. The first, recommending that Baltimore City Hospitals establish a detoxification center as one of its health services, is to be referred to the Baltimore City Medical Society. The second, aimed at reducing the number of highway accidents caused by alcohol intoxication, calls for a system of probation, similar to that in the Municipal Court of Baltimore, to be set up in traffic courts throughout the state. Under such a system, defendants in whom alcoholism is a major or contributing factor would be sentenced to a special program of treatment for alcoholism. The third, to establish an industrial clinic for alcoholism and drug dependency, was approved on a one-year trial basis. Re-evaluation will be made after the first year's operation to determine whether continuing approval should be given.

2. A fee schedule guide, presented by the chairman of the Fee Schedule Committee, was approved with the understanding that amendments could be made as necessary.

3. Physicians defense was granted to various members requesting it.

4. Settlement of several cases was noted.

5. Emeritus membership is to be requested for Nicholson J. Eastman, MD, Baltimore City; Manfred J. Gerstley, MD, and Eugene Kester, MD, Kent County; and H. Dabney Kerr, MD, Talbot County.

6. Deferment of dues until July 1, 1966, with all rights and privileges for the year, was granted for a physician on a fellowship. Another member had his 1966 dues remitted because of illness.

7. The 1966 budget was approved.

8. April 9, 10, and 11 were the dates approved for the 1969 Annual Meeting.

9. Approval was given to holding the 1966 Semiannual Meeting at the Diplomat Motel on September 9.

10. The action of the Executive Committee in urging members to cooperate with Blue Shield in the conduct of a survey to determine "prevailing fee" was upheld.

11. In reply to a suggestion that service benefits under Blue Shield be waived when the patient elects to occupy a private room, Blue Shield explained in detail why such a policy would be inadvisable.

12. E. David Weinberg, MD, was approved as curator to succeed Mason F. Lord, MD, who died.

13. Various Blue Cross and Blue Shield appointments were approved.

14. Various legislative items coming before the General Assembly were considered:

A) An amendment to the Medical Practice Act was approved for submission to the 1966 General Assembly. This would permit the Board of Medical Examiners to "suspend" or "place on probation," compared to the current provisions which permit only revocation.

B) The principle of the law which would require the medical examiner's investigation of occupational deaths is favored, but the portion dealing with the necessity of obtaining consent for autopsy from the next of kin is opposed.

C) Senate Bill 46 is to be supported. This would change the insurance law dealing with reporting suspected instances of suit in

professional liability cases. The change would not permit carriers to place cases on "reservation of right" without good cause.

15. Action was deferred on the matter of civil rights compliance on medical care cases pending an opinion from AMA concerning correspondence from the Department of Health, Education and Welfare which would require a statement that compliance was being met with.

16. Pathologists, radiologists, anesthesiologists, and physiatrists are to be advised of the Faculty's support in connection with reimbursement for their services under Medicare.

17. The President was authorized to discuss with news media representatives actions taken at the special closed-session House of Delegates or to designate a spokesman in his stead. He was also authorized to designate a spokesman for the Faculty to answer questions for the news media when immediate information must be given.

18. The Council acted as follows on recommendations of the Policy and Planning Committee:

A) Approved supporting proposed legislation to protect local or state professional societies and medical staffs of local hospitals when acting in good faith in disciplinary matters.

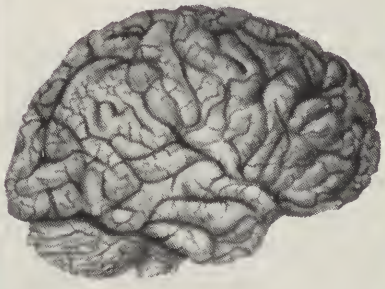
B) Approved formation of a special committee to consider changes in the Medical Practice Act as they apply to unethical or unprofessional conduct and disciplinary procedures thereof, both for members and non-members.

C) Approved preparation of a program on Medicare for broadcast over the MEDIC network as soon as pertinent information is available.

D) Deferred until the March meeting action on a proposal calling for a pilot study covering three areas of medical practice in Maryland:
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the educational fund was requested for this study, along with a request that an effort be made to find a source for additional funds for complete study.

HOUSE OF DELEGATES, JANUARY 29 SPECIAL SESSION

1. A resolution was adopted providing for establishment of a 16-member committee, representing the various organized specialty groups in the state, to assist in clarifying specific contractual arrangements and to aid in negotiating ethical contracts. The Bylaws were amended accordingly.

2. Article XIII of the Bylaws was amended to give the Executive Committee of the Council judical powers in disciplinary matters and to spell out procedures for disciplinary action.

EXECUTIVE COMMITTEE, FEBRUARY 17

1. Monthly payments from the Cordell Fund will be continued for another year for a physician in need.

2. Financial participation in the Conference of Presidents and Other Officers of State Medical Associations was declined.

3. Certain changes in fringe benefits for Faculty personnel and retired personnel were adopted.

4. A recommendation was approved to hold, on a one-year trial basis, quarterly meetings for executive secretaries of the component societies, with expenses to be borne by the Faculty.

5. Inclusion of government installations in the MEDIC network was authorized, with the government to pay the cost of leasing land-line equipment, rental equipment, and installation charges involved.

6. A recommendation favoring a demonstration model of a community mental health center to be set up in Langley Park was approved, subject to its approval by



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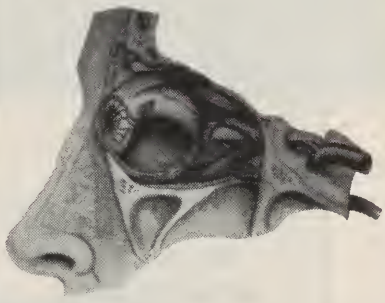
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the Prince George's County Medical Society.

7. A statement concerning administration by nurses of IV fluids, blood, and medications and another concerning closed chest resuscitation and artificial respiration by nurses were adopted.

8. John H. Hirschfeld, MD, was recommended as the Faculty representative on the Advisory group of the Regional Medical Program, P. L. 89-239.

9. Jack M. Zimmerman was selected to fill a vacancy on the Continuing Medical Education Committee.

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10. A request to pay for the expenses of a speaker on alcoholism at the Peninsula General Hospital was denied because the Educational Fund has been designated for statewide benefit rather than local benefit. If and when a speakers bureau is developed, a request for blanket funds for its operation would then be considered.

11. Bills before the State Legislature were considered. The Executive Committee approves the amended bill concerning legalizing abortion after rape; opposes a bill calling for issuance of medical certificates at specified intervals in connection with individual ability to drive; opposes a bill establishing a board of dispensing opticians.

12. Use of Osler Hall was denied to the Maryland Chapter, Medical Committee for Human Rights, as membership of this organization does not fall within the policy established for use of Facutly facilities.

13. A request that dermatologists be represented on the Blue Shield Medical Relations Committee was denied, inasmuch as representation is not based on specialty.

14. Social Security has advised that Montgomery and Prince George's Counties will be included under the DC Blue Shield plan for fiscal purposes.

15. The Fee Schedule Guide and supplemental information is to be distributed to active members as soon as possible.

16. Blue Shield is to be commended for its activities in educating physicians and their office assistants in Medicare procedures and is to be asked to coordinate its activities with those of the Faculty in the same area.

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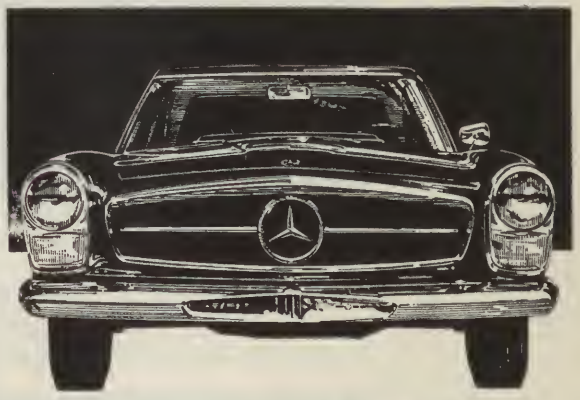


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EXECUTIVE SECRETARY'S NEWSLETTER

April, 1966

PREVAILING FEE PROGRAM OF BLUE SHIELD

All Prevailing Fee Program survey forms are being returned to individual physicians who submitted them by Maryland Medical Service.

The decision to take this action was reached by the Board of Trustees in view of the considerable amount of misunderstanding that apparently existed in connection with this Survey. Blue Shield plans to discuss this proposal with the Faculty, Component Societies as well as the various Specialty Groups during the next few months.

MEDICAL CARE FEE INCREASE

Included in the Health Department's 1967 Fiscal Year budget, commencing July 1, 1966, are sufficient funds for payment of $3.00 per office visit for medical care patients. No other fees were changed.

NEWS NOTES

Rafael Garcia-Bunuel, M.D., Baltimore, has been installed as Fellow of the American College of Obstetricians and Gynecologists.

Hak Suh Lim, M.D., Baltimore, has been certified as a Fellow of the American Society of Anesthesiology.

Jacob H. Conn, M.D., received the Presidential Certificate of Merit of the Society for Clinical and Experimental Hypnosis; as well as the Bernard B. Raginsky Award for, "leadership and advancement in the field of Hypnotherapy."

AD CAMPAIGN

The National Tuberculosis Association is embarking on a national educational campaign through ads in national magazines and periodicals. The principal purpose is to inform our citizens that chronic cough and shortness of breath may be early symptoms of disabling chronic obstructive airway disease. Those reading these ads are urged, "To See Your Doctor".

1966 GENERAL ASSEMBLY

Full details on the actions taken by the 1966 General Assembly have been mailed to all Faculty members via The Assemblyman. Additional information on specific bills may be obtained from the Faculty office.

IN THE WORKS

With the immense growth of legislation requiring physicians to report information to various governmental units, the need has become apparent that a compendium of such rules, regulations and requirements would be helpful to newly licensed physicians, as well as to others who have been in practice for some time.

This is presently under preparation and, hopefully, will be available within 2 - 3 months time.

PERSONALITIES

Russell S. Fisher, M.D., Baltimore, has been appointed chairman of the AMA's Committee on Medicolegal Problems.

REVISED COMMUNICABLE DISEASE REPORT

A revised Communicable Disease Report form, as well as listing of reportable disease, has been mailed to all Faculty members.

The new report forms, much simpler and easier to complete than previous ones, are available through the local health department.

Physicians are urged to comply with these new simplified regulations, as well as to cooperate in the national VD campaign by reporting promptly all cases of Venereal Disease that come to their attention.

UTILIZATION REVIEW COMMITTEES

With the advent of the Medicare law, hospital medical staffs will be required to have a Utilization Committee in the hospital, or in operation through the local medical society. The Faculty office offers assistance to local groups in the formation of such committees by providing background material, advice and other data.

John Sargeant

Executive Secretary

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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The Ultimate Hope

Our ultimate hope is complete eradication of cancer. Current research is bringing this goal ever nearer to attainment. Further investigations must be encouraged and the new knowledge put to practical clinical use.

MURRAY M. COPELAND, MD

As president of the American Cancer Society, I am privileged to give the Blessed Elizabeth Seton Lecture at St. Agnes Hospital this year. It was under the guidance and leadership of the distinguished surgeon and surgical pathologist, Dr. Joseph Colt Bloodgood, that I was first introduced to the cancer problem and encouraged to pursue a career devoted to finding the cause and cure of this dread disease. In the later decades of his life, Dr. Bloodgood did practically all of his surgery at this institution. It is with a sense of reverence and pride that I digress for a moment to speak of this great man whose shadow still falls across the portals of this venerable hospital.

History will record him as a dynamic man with robust physique, a contagious smile, and the inbred quality of a gentleman. In the evaluation of his career, his role as a surgeon pales in the light of his accomplishment as a surgical pathologist who brought the microscope into the operating room and, through the technique of the frozen section, had a great influence on surgical practice by bringing about the conservation of countless legs, arms, breasts, and other organs from mutilation. He will be remembered for his papers on tumors of bone and tumors of the breast and especially his interpretation of giant-cell tumors and chronic cystic mastitis as benign lesions and the handling of these disease processes by conservative measures. In the crusade against cancer, he was a cornerstone in the program of advocating the importance of the follow-up study as a technique for the evaluation of methods of diagnosis and treatment. May the results of his influence continue to have impact on the generations to come.

The ultimate hope of us all is to completely eradicate cancer through knowledge gained from research into the cause of the disease and its control which, in so many areas, remains an enigma. Current research in both clinical and basic science aptitudes is increasingly productive in the unremitting effort to unravel the problems which still confront us.

History will record that the people of our generation lived in one of those miraculous flowerings of the human intellect called a "Golden Age." Even now, man probes the cosmos—the nearby moons and planets and the distant stars. Even now, he explores the frontiers of knowledge within a single cell, a thousand of which could rest upon a needlepoint; and he tests there the reactions from infinitesimal amounts of en-

---

Blessed Elizabeth Seton Lecture, presented June 10, 1965, at St. Agnes Hospital, Baltimore. Dr. Copeland is president, American Cancer Society, Associate Director (Education); General Surgeon, Department of Surgery; Professor of Surgery (Oncology); The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston.

zyme and nuclear material. He does all this at the opposite outposts of space—in the cosmos and in a single cell—to find further intimations of man's origin, method of growth, and mortality.

A keen observer of the research scene recently said that more has been learned about cancer in the past 15 years than had been learned in all previous history. What have we learned about this disease over the total span of our effective knowledge? Let me enumerate some of the important observations:

1. That cancer is hardly to be regarded as a single disease, so varied are its manifestations, its rates of growth, its susceptibility to treatment.
2. That more than 500 chemical compounds can cause it under the conditions of experimental control.
3. That certain environmental circumstances of living and working favor its development.
4. That heredity appears implicated in certain kinds of cancer.
5. That the cancer process, essentially one of rapid cell division, is focused in a minute part of the cell which triggers the fission of the cell, the nucleus, the essential protein and enzyme complexes of which are partly understood.
6. That the chemical requirements of the cancer cell differ, at least quantitatively, from those of normal cells.
7. That these specific reqirements may be frustrated by chemical means.
8. That hormones are evolved in the genesis and continued growth of some cancers and that hormones will restrain the growth of certain cancers.
9. That viruses are the cause, or part of the chain of causes, of a number of animal tumors, and that there is increasing evidence that they are in some way related to human cancer.
10. That there is a protective immune mechanism for cancer, as for bacterial invaders, which can be demonstrated experimentally.
11. That human cancer can now be made to grow indefinitely in animal hosts and in tissue culture after transplantation from humans.
12. That cancer is not an instantaneous conversion of a normal cell to a malignant one but is a developmental acquisition, a terminal phase of a series of changes.
13. That half of all cases of human cancer today can be cured, but, in fact, only about one-third are being saved.

Words familiar from long usage — viruses, genes, mutation, cancer—have begun to shift in their meanings and to take the form of oblique attempts to describe not separate entities but different manifestations of one particular and fairly well-defined type of chemical substance, DNA (deoxyribose nucleic acid). From this new vantage point, the argument about whether or not viruses "cause cancer" begins to seem outmoded, as it becomes clear to all engaged in such research that the link between cancer and viruses may be as strong as the coil of life itself.

This decade may well be memorable for the opening of a new front in the war against cancer. Some of the events we have predicted so hopefully and for so many years in such vague terms as "the foreseeable future," "in our time," or "eventually" actually seem to be coming to pass. Now. Today.

Brilliant scientists tell us of new facets of their work. Some of their findings and techniques even now are beting tested or applied for the first time against human cancer. In most cases, it is too early to tell how effective these findings or proposed curative measures will be.

We cannot be satisfied with present medical means for cancer control. We need not be. As I see it, these are some of the most urgent and practical measures we expect from science and medicine, some of which now are being tested experimentally in humans as well as in the laboratory:

1. Blood, urine, and biochemical tests which will indicate not only the presence of early and hidden cancers but also an individual's susceptibility to specific cancers.
2. The detection of hidden cancer viruses of cancer-causing organisms and the designing of drugs which will inhibit their growth or destroy them.
3. The development of safe and effective vaccines to prevent specific cancers.
4. The application of immune measures—vaccines, antisera, antibodies, sensitized lymph cells, immunity stimulants, lytic enzymes,

interferon, and other substances—which directly or indirectly may suppress cancer growth.

5. Widespread public knowledge of the chemicals which cause cancer in experimental animals and their elimination, as much as possible, from man's food and environment.
6. Exact information on the biological activity of x-rays for the guidance of physicians, dentists, and others who use this cancer-causing and cancer-curing medium.
7. New and better anticancer drugs and their use, alone or in combination with surgery, radiation, and immune measures, with maximum effectiveness and safety.

Progress in cancer research during the past 10 years has led to the current interest in the role of viruses in the development of human cancer. Many new viruses have been discovered in man, and many cancer viruses in animals, only to mention leukemia virus and the multipotent gland tumor virus of mice.

Recently, a malignant lymphosarcoma was reported in children of certain regions of Africa. The disease affects Negro, Asian, and European children, alike. It is, therefore, a disease not of Africans but of Africa. Closer examination has revealed that these children with lymphosarcoma have other types of tumors, also, in their bodies. Only those children who live in certain regions at low altitudes and of small rainfall are affected. The present question is whether mosquitoes or tsetse flies are involved in the transmission of the disease, as the regions correspond with those where these vectors abound in Africa. Cattle in Africa also have been reported to be affected by this syndrome of tumors. It is not yet known whether this disease is virus-induced, but viral-like bodies have been found in the blood and lymph nodes of both cattle and humans with this disease, strongly suggesting that this may be so.

Leukemia and lymphosarcoma in cattle have recently received increasing attention. Some herds of cattle in this country and in Scandinavia have an incidence of leukemia as high as 80%. It has been shown that the disease is transmitted both vertically and horizontally by unknown means. The question arises whether virus in cattle, as in leukemia of mice, may not be transmitted by mother's milk. Dr. Dmochowski of The University of Texas M.D. Anderson Hospital and Tumor Institute has recently found viruslike particles, as yet of unknown activity, in the milk of leukemic cattle. This problem is receiving his great attention. Even if these viruslike particles are found to be the responsible agent, it is still a far cry from answering the question: can milk of such cattle be responsible for some cases of leukemia in man? This fact of the problem is being studied.

In 1957, Dr. Dmochowski first demonstrated viruslike particles in a lymph node from a child with acute lymphatic leukemia. More extensive study has since been carried out on biopsy material from lymph nodes of patients with acute and chronic forms of leukemia, Hodgkin's disease, and lymphosarcoma. In some of the cases of acute leukemia, viruslike particles have been found in the leukemia cell cytoplasm as well as in one or two cases of lymphosarcoma. These findings have been confirmed by Dalton and Maloney, of the National Cancer Institute, in 16 of 20 patients with acute leukemia. The particles were not present in patients used as controls. While a virus has not yet been demonstrated as the cause of human leukemia, the abnormal particles found in these cells may prove to be a contributing factor.

In papilloma of the larynx, viruses have generally been suspected as being the causative agent. This tumor is clinically potentially serious because of its location on the vocal cords or any other part of the larynx and because of its tendency to recur after removal. While most common in children, it also occurs in adults, frequently leading to squamous cell carcinoma.

Heretofore, characteristic viruslike particles have been observed in human skin warts and in molluscum contagiosum, an infectious benign tumor of the skin in man. Recently, Dr. Dmochowski and his associates have prepared laryngeal papillomas from a number of cases, both children and adults, for electron microscopy. Examination of the first case of recurrent laryngeal papilloma in a 50-year-old man has revealed the presence of great numbers of characteristic viruslike particles in the nuclei of cells. Similar viruslike particles have also been found in a second case of laryngeal papilloma in a 2½-year-old girl. The viruslike particles are similar in size and location to virus particles of human skin wart, papilloma of rabbits and, in appearance

and location, to virus particles of polyoma of mice and of SV-40 virus of monkeys. Although this is a first demonstration of viruslike particles in cells of human laryngeal papilloma, further studies will be required to establish their causative relationship to the tumor.

Dr. Breslow, of the University of California's Public Health Department, who is a member of the American Cancer Society's board of directors, calls cancer a pre-eminently social disease and says that those who would understand its genesis and work toward its control must look upon it as a public health problem. He defines it is a social disease in at least three major respects: 1) social conditions contribute heavily to its cause, 2) social measures are required for its control, and 3) the social and economic circumstances and pressures that influence each case must be understood and respected.

While there appear to be more than 300 different types of cancer and probably hundreds of causes, few doubt any longer the statistical and laboratory evidence that cancer has social and cultural causes. Typical examples include the higher incidence among certain miners, the carcinogens found in food additives and farm chemicals, the high leukemia incidence among the people of Hiroshima, and the apparent cause-and-effect relationship between heavy cigarette smoking and lung cancer.

As evidence of socioeconomic influences on the course of cancer, a recent survey in California uncovered these facts, among others:

1. One out of every four patients had failed to follow through with the medical or surgical treatment recommended by his physician.
2. One in three had been afflicted by serious family or emotional problems before entering the hospital.
3. Three out of five faced even more serious problems after leaving the hospital.

While the survey indicated that some patients failed to follow through with treatment because of their refusal to accept the implications of an apparently hopeless diagnosis, it was evident that most were influenced by emotional problems, financial worries, or the immediate problem of family responsibility. In view of the fact that the outlook for patients who follow through with treatment is far more hopeful, it is evident that we could save thousands of lives with an intensive effort to ease the problems, the resistances, and the fears that beset so many of them.

A splendid tool for understanding the public health aspects of cancer is California's Tumor Registry, which now contains on the tapes of its computers a 21-year record of the case histories obtained from more than 250,000 cancer patients. From these records, Dr. Breslow has extracted evidence indicating what he calls the "class consciousness" of cancer and its treatment:

1. Cancer of the cervix is twice as frequent in the lowest income group as in the highest.
2. Among men, lung and stomach cancer strike the lowest income group twice as frequently as it does those with the highest incomes.
3. Only one-third of the cancer patients in county hospitals had received the benefits of early diagnosis.
4. As a result of earlier diagnosis and better treatment, 62% of private hospital patients with cancer of the cervix lived five years or more; only 39% of the county hospital patients lived five years.
5. In California's Alameda County, two-thirds of the women in the highest social class had received at least one Papanicolaou vaginal smear test; less than one-third of those in the lowest economic group had received such a test.

It is unfortunate that those with the greatest need should benefit least from the most effective means now available for cancer control. Correcting the imbalance will require serious organized effort. Individual education must be reinforced by a network of responsibility.

At best, our knowledge of how to control cancer is modest, if mortality statistics are a good index. Yet this is an unwise conclusion, because our knowledge of the origins, treatment, and possible cure of the disease is catching up with the challenge.

While we must observe every caution in protecting cancer patients from overt or occult ill effects of new medical preparations and techniques, no time should be lost in making new medical discoveries available. The medical value of a scientific discovery is only as great as its

application to human health problems. The medicine which for centuries has served only primitive tribes is of no value to populations too preoccupied or too sophisticated to test it. This for a long time was the case with tranquilizers. Biological principles which are buried with their discoverers—Mendelian genetics is an example—are of no value until they are rediscovered by a more curious, more tolerant, and more alert generation.

In the present information explosion, in which thousands and thousands of journals inundate us with more or less unsorted facts, artifacts, figures, charts, observations, speculations, and logical and illogical conclusions, there is risk that we may be ignoring some of the biological keys of cancer control. This we cannot afford. It is incumbent upon us to devise a system for exploring any promising avenue against cancer opened by an honest and competent investigator. I believe that the enthusiasms of scientists for their work should be encouraged; cynicism will never cure cancer.

Beyond the difficult job of developing new knowledge is the equally formidable task of applying the solutions arrived from basic research to clinical problems. The life-saving experimental technique will save few lives if it is not tested by capable and conscientious physicians, if it is not shown to be reproducible, and, once found practical, if it is not generally adopted and made available to patients requiring it.

I wish to quote the epilogue from the Sloan-Kettering Institute for Cancer Research, Progress Report for 1962, as an expression of our hope for the future:

> One hundred years ago, a haphazard, seemingly meaningless collection of scientific data was suddenly fused into a synthesis that altered forever not only the course of biological sciences, but the entire pattern of human health and welfare, when Louis Pasteur delivered, at the Sorbonne, his famous lecture on spontaneous generation and announced the germ theory of disease.
>
> Once more we are groping in the strange twilight between the living and the non-living for unifying concepts of a great mass of curiously related information. Everywhere we direct a pinpoint of light, the mind is confronted with events as miraculous as the formation of life from a shining drop of synthesized DNA. Predictions are not only presumptuous at such a time, but they appear pale and unimaginative when contrasted with the facets of on-rushing event.
>
> We have every hope that these discoveries may ultimately mark the end of some of mankind's cruelest diseases; we are permitted to hope also that they will liberate the mind to travel further and further into unexplored regions, at least as exciting and full of promise as the frontiers now beckoning beyond the distant stars.

It must be apparent to all of you today that we are witnessing the beginning of a revolution in the biological sciences that will far surpass the great revolution in the physical sciences that culminated in the discovery of nuclear power.

It is not expected that the problem of cancer will be solved in a sudden flash of discovery. Trained investigators all over the world are seeking parts of the scientific jigsaw puzzle which, when fitted together, should give the complete picture. Holding these workers together is the ever expanding body of knowledge in a wide spectrum of scientific disciplines. With our scientific know-how, economic strength, and professional leadership, I am confident that discoveries extant and to come will ultimately mark the end of one of man's cruelest diseases. God speed the day!

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Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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April 27 and 28 at the Alcazar, Baltimore

HOUSE OF DELEGATES MEETINGS

Osler Hall, Faculty Building
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TUESDAY, APRIL 26—8 PM
FRIDAY, APRIL 29—9 AM

All members welcome

WEDNESDAY, APRIL 27
The Alcazar

AM

10:00 RELATIONSHIP OF VASCULAR THROMBOSIS TO SYSTEMIC DISEASE
Standish McCleary Fund Lecture
Donald G. McKay, MD
Columbia University

10:30 PHAGOCYTOSIS AND DEGRANULATION
William Royal Stokes Memorial Fund Lecture
James G. Hirsch, MD
Rockefeller Institute

11:15 FAMILIES AND PHYSICIANS
George M. Boyer, MD Fund Lecture
John Parks, MD
George Washington University

WEDNESDAY, APRIL 27

The One West, Baltimore

12:30 PM **ROUND TABLE LUNCHEON**

A luncheon with the experts—24 different medical topics and moderators from which to choose. An opportunity for an informal informative discussion

PM

2:15 URINARY STASIS AND URINARY INFECTIONS IN FEMALE PATIENTS
J. Mason Hundley Annual Lecture
Houston S. Everett, MD
The Johns Hopkins University

2:45 MEDICINE'S RESPONSIBILITY IN THE POPULATION EXPLOSION
I. Ridgeway Trimble Fund Lecture
H. Curtis Wood, Jr., MD
Assn. of Voluntary Sterilization

3:30 SPLENECTOMY IN THE TREATMENT OF HEMATOLOGIC AND NON-HEMATOLOGIC DISORDERS
J. M. T. Finney Fund Lecture
Robert J. Coffey, MD
Georgetown University

8:30 ALCOHOLISM AND THE LAW
A Medicolegal Symposium
Frank L. Iber, MD
Harry E. Shelley, LLB, ThB
Robert C. Embry, Jr., LLB

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APRIL 27 and 28

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THURSDAY, APRIL 28
The Alcazar

AM

10:00 TUMOR VIRUSES AND VIRUS TUMORS
Harvey Grant Beck Memorial Lecture
Alan S. Rabson, MD
National Institutes of Health

10:30 SYPHILIS: THEN AND NOW
Rudolph H. Kampmeier, MD
Vanderbilt University

11:15 PERCUTANEOUS CORDOTOMY AND THE MANAGEMENT OF SOME INTRACTABLE PAINS
John (Sean) F. Mullan, MD
University of Chicago

NO REGISTRATION FEE — CREDITS GIVEN BY ACADEMY OF GENERAL PRACTICE

ALL physicians and paramedical personnel are INVITED TO ATTEND the above sessions, including the Bermuda Cruise Convention

A detailed program will be mailed to all members, and to others upon request

John Collins Harvey, MD, chairman, Committee on Program and Arrangements

April 29–May 4, Bermuda Cruise Convention, aboard SS Argentina

PM

2:15 POSTGASTRECTOMY SYNDROMES
Amos R. Koontz, MD Memorial Lecture
Walter F. Ballinger, II, MD
The Johns Hopkins University

2:45 CARCINOMA OF THE STOMACH
Amos R. Koontz, MD Memorial Lecture
Robert W. Buxton, MD
University of Maryland

3:30 ORGAN TRANSPLANTATION: REFLECTIONS OF THE HOST'S RESPONSE AND ITS MODIFICATION
Jesse C. Coggins Fund Lecture
Gustave J. Dammin, MD
Harvard Medical School

THURSDAY, APRIL 28

Sheraton-Belvedere Hotel, Baltimore
6:15 PM Reception
7:15 PM Presidential Dinner

Entertainment
Betty Beneé—vocalist
Larry Wilde—MC and comedian



Betty Beneé



Larry Wilde

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available to
Members of the Faculty
WEDNESDAY and THURSDAY,
APRIL 27 and 28
8:30 AM—5 PM
The Alcazar, Baltimore

APRIL 29—MAY 4
SS Argentina
Bermuda Cruise Convention

W. H. C. Masters, MD, ChB
Bermuda Medical Associates Member of Parliament

ENDOMETRIAL ASPIRATION BIOPSY
Ernest I. Cornbrooks, Jr., MD
University of Maryland

SURGICAL TREATMENT OF HEART BLOCK
Frank A. Faraino, MD

SURGICAL CONSIDERATIONS IN GASTRO-INTESTINAL BLEEDING
Karl F. Mech, MD
University of Maryland

MANAGEMENT OF INTESTINAL INFLAMMATORY DISEASES OF UNKNOWN ORIGIN
Moses Paulson, MD
The Johns Hopkins University

WALDENSTRÖM'S MACROGLOBULINEMIA: A FAMILY STUDY
Richard N. Peeler, MD
The Johns Hopkins University

SEX IN MARRIAGE COUNSELING
Jonas R. Rappeport, MD
University of Maryland

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A Presidential Address

CRITIQUE OF THE MEDICAL PROFESSION

SAMUEL MORRISON, MD
Past-President, Baltimore City Medical Society

While I realize that in some quarters praise is richly deserved, I am not here tonight to praise the medical profession. I am well aware that no other group of people has quietly and unselfishly done more than the medical profession to carry out its utmost reasons for existence; namely, the health of the people, the education of its colleagues, students, and patients, and the basic research so essential to it all.

But my message tonight is one of constructive criticism. Here we are—educated and presumably wise men; yet our horizons are so limited. Why are physicians so conservative—if not reactionary? Why do we see communism and socialism in every attempt at social change? Why do so many doctors fight to maintain the status quo in this rapidly changing world? Why do we not recognize that socio-economic problems, slums, problems of population explosion, political problems, individual rights, crime and punishment, problems of the atom and nuclear devices, of automation, of jet propulsion—are *our* problems, too—problems that require bold and original solutions? Why are we so obsessed with the need to hold the line? What line? The line of an era we have outgrown? Why do we fight our own government instead of taking a positive, constructive position of leadership? It has been said that minds are like parachutes, they only function when open.

It is comforting to know that the things which concern me concern many of us, such as the urgent need for us to participate in health planning under Medicare. It should not be obstructed by those who think that non-participation brings solutions. There will be a need for continuous study of the actual results of this great experiment. These studies should be undertaken by specially organized groups under private auspices, the objective being to evaluate and improve the laws under which we administer medical care for the aged and perhaps other programs which undoubtedly will be forthcoming.

In 1916, a committee report to the AMA House of Delegates contained this admonition:

> Blind opposition, indignation, repudiation, bitter denunciation of these (social) laws is worse than useless. It leads nowhere and it leaves the profession in the position of helplessness if the rising tide of social development sweeps over them.

These prophetic words were not heeded then, nor yet in 1965, when the AMA showed no real willingness to compromise; made no move to have a part in framing the law that would inevitably emerge from the new Congress, though they must have been reminded that their own House of Delegates once endorsed a compulsory national health insurance program. "The time has come when we can no longer resist the social movement," the Board of Trustees said in 1916, "and it is better that we should initiate the necessary changes than have them forced on us."

It is true that yesterday political activity gave

Delivered before the Baltimore City Medical Society, December 3, 1965.

us little concern. Yesterday we were content to practice the art of medicine, but today we are being forced into the political arena, and we must realize that in the future many facets of medicine will be subject to political influence. Certainly we sometimes long for the "good old days," when the medical society was concerned solely with fighting disease and protecting the physical and mental health of the community. They were easier and very pleasant, but the real world is about us and demands our participation. Medicine today is more than ever bound up with life and death, with Vietnam, with revolutions, with the political right and left, and with the many other social and political problems of our nation.

One vital problem is the spiralling cost of medical care. Who is to blame? Patients seem to have a blind spot: they demand more personal care in a machine age in which they themselves are partly responsible for the rising costs. They have some mistaken idea that the more tests which are done, the more likely the diagnosis will appear. They do not realize how expensive some of these tests are. They seem to think that because the tests are paid for by someone else, the more the better.

Doctors, too, are to blame. They agree to the ordering of more and more tests. The teaching programs of the hospitals are expensive, sometimes wasteful, and not always well organized. The personnel itself is expensive. According to a fee schedule of the American Society of Internal Medicine, doctors' charges have increased to a point where they must be reflected in insurance rates and other interrelated costs, thus adding to the inflationary spread. Its aims and purposes are documented, but one of the reasons for the founding of the American Society of Internal Medicine was to establish higher fees for internists. But it is *not true,* as one of our colleagues charged, that the doctor's dominant motivation is money. Such an unfair accusation could only have been made by one who does not practice on a fee for service basis with his patients.

Even the government is abetting the rise in medical care costs. Certainly the original concept of taking care of the ill who cannot afford care is acceptable. But some of the governmental programs with their unfairly low fee charges of $2.50 for office visits often lead to more office visits and more prescribing than seems proper. Thus, by degrees, we are being drawn into a system which we recognize as undesirable.

I have neither the knowledge nor the fortitude to discuss all the phases of health insurance, what they offer, what they really give; but I can tell you how wrong it is to sell insurance which offers, for example, to pay the cost of x-rays only when they are done in the hospital. Our hospitals cannot even take care of all the sick promptly; yet these programs are accepted and patients are hospitalized for these purposes. I cannot approve of the policy of some hospitals—a policy often ignored by Blue Cross—which refuses to accept a patient's Blue Cross until a semi-private accommodation is available. It is like selling something which is not available to the public.

The rates in the hospitals reflect the many increasing costs. I believe we, the medical profession, should set an example and hold down excessive financial demands on people at their worst time—when they are sick.

Apropos of hospitals, I for one am awfully tired of being asked by a lay person in some of our admitting offices why a particular patient needs to be admitted. And how does one react to an admitting clerk who acts stunned when called for the admission of a patient? These practices are condoned by the hospital authorities, I presume because the person in such a frustrating job is doing the best that can be done. Yet, such a person has no right to practice medicine.

To return to the matter of spiralling medical costs, anyone—physician, hospital administrator, government agency, insurance carrier, patient—who has anything to do with a visit not essential, a prescription not necessary, a test not required, the use of equipment and personnel in treatment not indicated, who condones actions which adversely affect the service, or who bows to demands which his judgment tells him are unwarranted, is contributing to the spiralling cost of medical service. And it is the cost of medical service which will, in the final analysis, determine the degree to which our profession will be able to resist the encroachments of the government and the measure of control we can retain over our own destinies.

I have always been concerned about the lack

of accreditation of hospitals in our community. I believe that only when all the hospitals of this community regard lack of accreditation in any one of them as an obligation on all of them, will we have arrived at a mature attitude. I do not see why any hospital in our area should be unaccredited. Nor do I see any sense to partial accreditation, whereby, for example, the surgical or gynecological service is accredited but not the medical service.

Community hospitals should not periodically fear loss of accreditation. As an example, they are told, "Your outpatient clinics do not have enough patients"; so the hospitals are compelled to drum up more patients. Why should chiefs of services, administrators, and accrediting bodies lay down rigid rules which treat us as if we are irresponsible and make for dodges and tricks which are unbecoming to mature physicians? The common point in these examples is sterile thinking. Conformity and uniformity have become ends in themselves. But why? Was Edison a conformist?

Accrediting bodies should advise, assist, and promote. They should not threaten or coerce or punish. Are not honor, integrity, and responsibility part of our unwritten code? To be periodically confronted by the spectre of accreditation represents a drain on energies which might be better expended in other directions.

Dr. Irvine H. Page, in writing about the new *Journal of the Reticuloendothelial Society,* commented:

> Clearly the day of intense specialization is with us and, equally clearly, if specialization proceeds in a narrow path without relationship to other paths of knowledge, our great body of knowledge will end up in limbo.

Dr. Page calls for vigilance to see that we, personally, our specialty boards, and our societies do not demand conformity to the point of preventing creation of a broadly conceived and relatively homogeneous body of medical knowledge.

> While being specialists, we still must be generalists; while being physicians, we still must be scientists; and lastly, while being scientists we still must be men. It is a big order, and we can only succeed if we help each other, a cardinal principle of medicine and science too often forgotten.

Dr. Jacob K. Berman, in an article entitled "Survival With Prestige," reminds surgeons to treat the patient as a whole, not as a number, an experimental problem, or an illness. He recalls that almost a century ago, Jonathan Hutchinson said, "It is more important to know the patient than his disease." It may become more important, I add, to know our society.

Basically I have great affection for my colleagues, and I am sure that they have as much sentiment as I. I would like to see a little more humor, a few well meant smiles. This is what helps to make men great. I would like to see less moral indignation among certain groups of physicians. What concerns me about indignation is that it should not be so cynically selective.

I do not see among my colleagues a display of emotional response such as that shown by Sir Winston Churchill, when he said, "In war, resolution; in defeat, defiance; in victory, magnanimity; in peace, good will."

In contrast, Americans have been accused of spending too much time in competitive enterprise, in bettering last year's effort, in commercializing everything they touch. But The Almighty would not wish it this way. There is so much compulsion, dogged determination, perseverance, and persistence on an issue such as corporate medicine, when all of us know how we stand, and we know how well this symbiotic relationship has worked over the years.

Two hundred years ago the poet Robert Burns wrote, "Oh wad some Pow'r the giftie gie us, to see oursel's as ithers see us." And Lincoln, in his last inaugural address, said, "With malice toward none, with charity for all, let us try to bind up the nation's wounds." Perhaps we need a period during which we should bind up our own wounds.

It is true that sometimes we have no choice in our enemies, but have we as many enemies as we imagine? Is, for example, the government our enemy? We decry governmental interference in medical care programs and enforcement of drug standards, yet we clamor for federal funds for research and hospital construction. We fear big government, yet the upsurge of crime and violence make us demand federal action. Expedience should never come before humanity, and I am sure the test of conscience will not find us wanting.

In the *Johns Hopkins Magazine* for March, 1965, James Reston asks if we are ready for the Great Society. We should behave toward our country, he said, quoting J. B. Priestly,

as women behave toward the men they love: a loving wife will do anything for her husband except to stop criticizing and trying to improve him. This should be the attitude of a citizen, suggests Mr. Reston. He raises such provocative questions as, "Which is more important, the conquest of the moon at $5 billion a year or the education and housing of the poor?" And he ends on the optimistic note of Justice Holmes: "Beyond the vision of battling races and an impoverished earth, I catch a dreaming glimpse of peace."

Let me address myself to the all-important point. How broad *is* our horizon? Wake up, profession! Wake up, MD's! So often we win a battle and lose the war; we win a point and lose the issue. One of our troubles is that between the young geniuses in high positions and the older ones who wish to live in the past, we fail to make use of the fertile minds of many mature, wise, and experienced men in the middle group, men who know when to compromise, men who know that step by step progress leads to the desired objective. Man was never meant to be one dimensional. Progress lies not only in conformity but in the development of new ideas.

Excluding those who do not even participate, there are so many who talk but never listen, who look but never see. Yet the world is crying for intelligent interaction between human beings. Let us talk sense amongst ourselves and to our patients and hope that they in turn will talk sense to us. It is not right for us to stay above the battle; to remain aloft is to die before life begins, and it is when good men do nothing that others take over. We must be mindful of the lessons of the past; we must be alert and responsible in facing the problems of the present; we must be creative and courageous in meeting the challenges of the future, and we must not let the pressures of our troubled times swerve us from these objectives.

Dr. Howard P. Lewis, in an article entitled "Reflections From Our Mirror," in the *Annals of Internal Medicine,* said,

> We must recognize that today we are less close to our patients than we should be and that we have not taken into full account, as individual physicians, that we and our times have changed.

There is no question that the physician, busy as he is, must find time to participate to a greater degree in many important and demanding civic and professional activities because these have become expected of him. Community leadership as a whole has a tremendous role to play in redirecting and reorienting basic thinking to encourage a little less negativism, a little more positive approach, a little less emotionalism, and a little more common sense.

Amidst great material well-being, our culture stands in danger of losing its very soul. The state of the humanities today creates a crisis for national leadership. Mankind is nothing without individual men whose minds are able to take part in a revolution and to make their contribution for all.

This is so different from a recent note I read about television, which concluded that it makes the most money by catering to the biggest audiences, that culture does not pay, so the heck with it.

Medicine's limitless horizons are before us. They are inspirational. The monolithic society is no more. Motivation and responsibility are basic to progress. Might we not aspire to having a medical man in the cabinet, one who enjoys both the confidence of the President and the confidence of his colleagues? One who would take part in policy-making rather than obstructing it, or coming up too late with too little?

In an address titled, "Time Does Not Permit," Dr. Ingelfinger made some interesting comments, among which was that he had many ideas that impressed him as most important which he could, unfortunately, not impart to his listeners because time did not permit. I know this feeling.

I have indulged myself in your valuable time. I have undoubtedly stunned many of you, angered more; but I, too, have been stunned and angered during this year as president. I have been hurt. No casts are visible, but I have aged, and my brain tells me that the wounds have seared deep into my soul. I am worried about our future in terms much broader than the medical profession has allowed itself to envision. I implore each of you to ask yourself the profound question: Do we want leadership in this amazing century, or do we want to hold the line? Do we wish to be above or below or in the battle? We have a choice. I have made mine.

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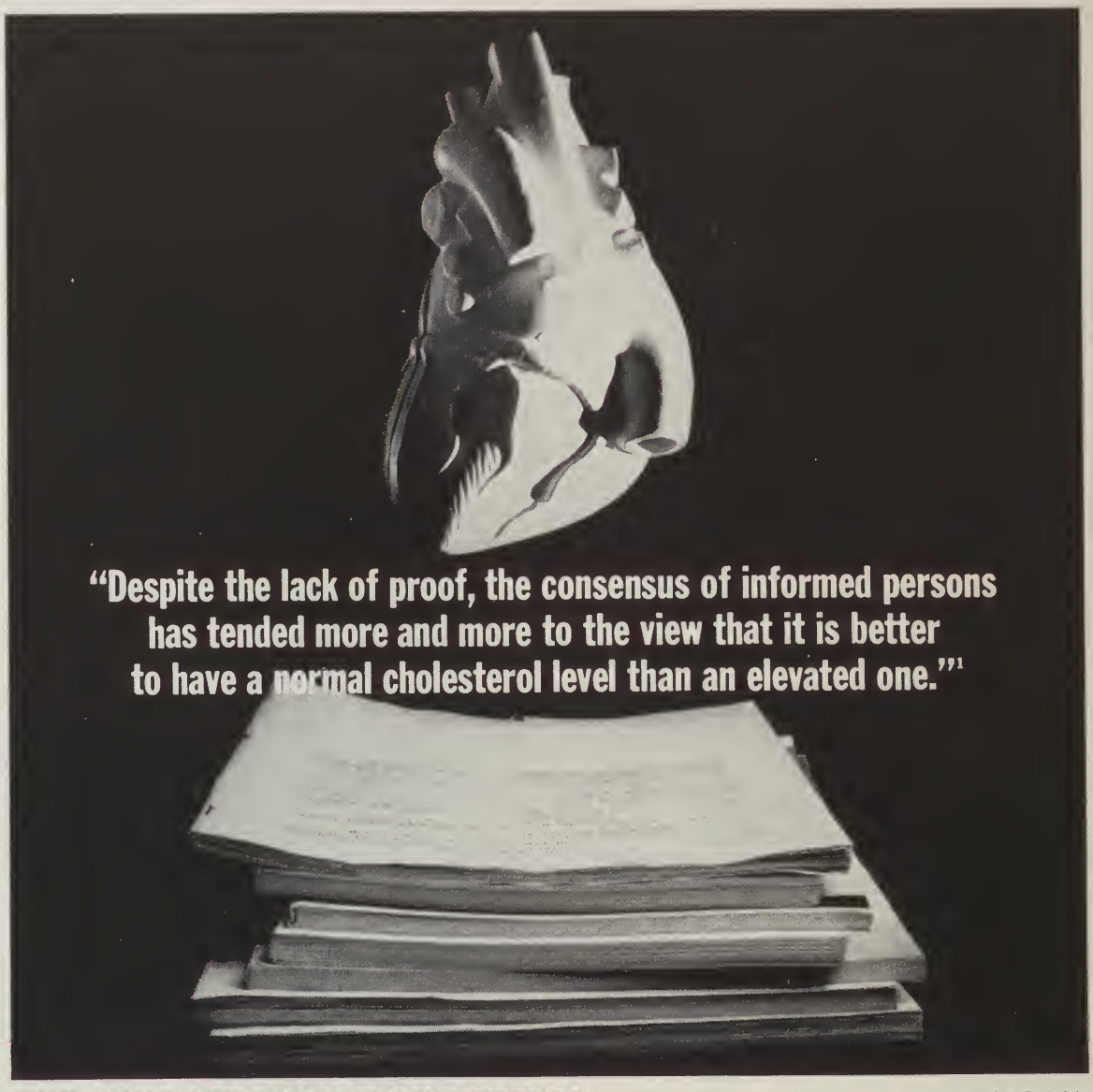
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REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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BREAST CANCER

Current Concepts in Clinical Management

The breast is the number one site of cancer in women; in the United States it is the leading site of cancer incidence regardless of sex. Four aspects of the problems and management of breast cancer are considered here: history taking, mammography, castration, and treatment.

EDWARD F. LEWISON, MD
Breast Clinic, Johns Hopkins Hospital

Among the many polished phrases and published wit of the late and great President Kennedy is the remark, "When things are noncontroversial, beautifully coordinated and all the rest, it must be that there is not much going on." This certainly can't be the case for the polemics and problems of breast cancer, where contradiction and controversy are rampant and so often regarded as stubborness versus stupidity. Even men of moderation who are unwilling to accept the comfortable cliché and traditional techniques and teachings of our predecessors are frequently considered the devil's allies in this disease —those who doubt are damned! However, these nonconformists are often the martyrs of science consecrated to the cause of truth. By challenging our current dogma they enrich the science of surgery and enhance the progress of our medical profession. As noted by Sir William Ogilvie,[11] "It is an ancient and fundamental problem of all institutions to combine security with progress, tradition with discovery"—and surgical orthodoxy with heterodoxy.

Before considering specific subjects pertaining to the practical problems of breast cancer and its clinical management, I would like to define the magnitude of this disease in broad general terms. Cancer of the breast has a worthwhile distribution and is in truth an arrant "world citizen" whose cellular turmoil shows little predilection for race, country, or geographic distribution. Morbidity studies in the United States indicate that the incidence of cancer in the breast is higher than that for any other single site in either sex. In women the breast is the number one site of cancer, the most frequent organ to be attacked by this malign and monstrously destructive disease. Between five and six per cent of all women—more than one in 20—is destined to develop breast cancer, and the risk of this possibility increases steadily with each decade of life (fig. 1). Breast cancer is the leading cause of death from malignancy for women between 40 and 60 years of age. This disease has a long and painful history, a dire present, and, thus far, a devastating future.

History Taking

I shall discuss briefly four topics pertaining to the practical problems of breast cancer and its clinical management. The first is history taking.

The differential diagnosis of a lump in the breast often depends upon a detailed medical history and a careful physical examination sup-

Presented before the Baltimore City Medical Society, October 1, 1965.

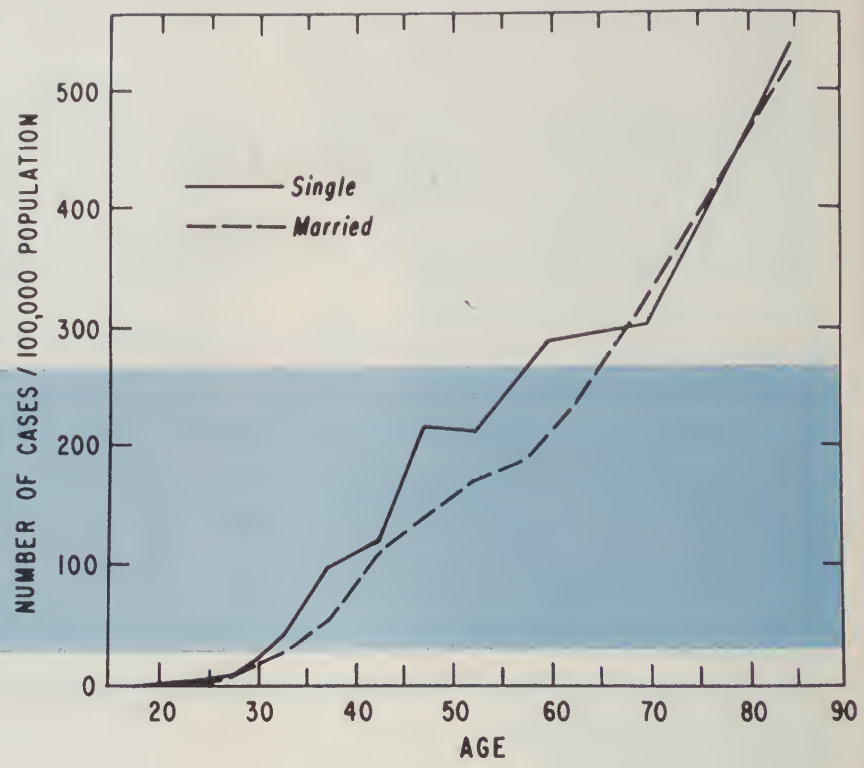


Fig 1
Breast cancer incidence rates, by marital status. Incidence is ever-increasing with each decade of life. Single women have a higher incidence of breast cancer than married women.

plemented by meaningful diagnostic instrumentation. Since the classic and cardinal concept of breast cancer and its successful treatment is based upon early diagnosis and early treatment, time is of the utmost importance. Although early breast cancer is not necessarily measured in minutes or months, but rather in malignancy and metastases, there can be little doubt that breast cancer is more curable when the diagnosis is early, the lesion local, the growth rate low, and the host resistance high.

In taking a detailed family history, past history, and present illness, one often finds a rich reservoir of medical information. There are antecedent factors of striking significance, such as a strong family history of cancer in certain kindred or family groups. The marital-pregnancy status of patients is important in view of the known increased prevalence of breast cancer in women who have never married or have never borne or breast-fed children (fig. 1).

Today, history taking must include a careful inquiry into the use of newer drugs, cosmetic preparations, and certain oral contraceptives. Within the past few years a convincing array of medical articles have pointed to the phenothiazine derivatives, tranquilizers which are in such common use, as the major cause of spontaneous and unexplained nipple secretion. Cosmetics containing hormones are usually costly creams which embody estrogens and are liberally anointed as a nocturnal ritual by many of our ageless females in their quest to remain "a thing of beauty and a joy forever." However, these hormones may cause mastodynia, breast engorgement, and aggravation of chronic cystic mastitis. Both cortisone and digitalis have been reported to have a growth stimulating potential upon both the male and female breast. Digitalis has several estrogen-like activities,[10] including cornification of the vaginal epithelium in postmenopausal women. Oral contraceptives contain a hormone combination of progestogens and estrogens. These cause breast pain, engorgement, and an increase in nodularity in some, but not all, patients with benign breast disease. The oral contraceptives are certainly contraindicated in women who have been operated upon for cancer of one breast, and I would hesitate to recommend them in other high risk population groups where the danger of breast cancer is increased.

Among our modern medical miracles there appears to be a passion for panaceas which permanently perpetuate youth. Although I have heard

it said with sadness that "wrinkles are the furrows wherein women bury their illusions," I am gravely concerned about this growing tendency toward medicinal rejuvenation. The indiscriminate use of estroegns from the "womb to the tomb" may be a serious source of danger. These growth stimulants are not necessarily the elixir of life; if taken over a long period of time, they may cause harmful changes, particularly in the breast and female organs. Randall[12] has noted a significantly lower incidence of deaths from malignant diseases among women whose preclimacteric menorrhagia was managed by the removal of the estrogenic influence by oophorectomy—a decrease in the estrogenic environment. I, for one, am not convinced that hormones are an unmixed blessing and that this "fountain of youth" is required for the salvation of all postmenopausal women in their "rendezvous with destiny."

Mondor's disease is a superficial thrombophlebitis of the veins of the breast. Once an uncommon and little known clinical entity, it is being recognized more often because it is easily confused with breast cancer.[4] Its cause is unknown, but it is frequently associated with a history of either severe or trifling breast trauma. If the dictates of the House of Dior prevail in popularizing the plunging neckline with the heavily underwired bra, the menace of the "merry widow" and the wired bra as a unique cause of Mondor's disease may become a malady of major magnitude.

Mammography

The second subject of practical importance in the clinical management of breast cancer concerns the mirage or millenium of mammary diagnosis by mammography. The widespread and exaggerated interest in this method of x-ray diagnosis has been propagated by a few enthusiasts with extravagant and persuasive claims. Although mammography is at best a gross diagnostic procedure, its merit lies in its new and objective approach to the difficult problem of differential diagnosis by clinical examination alone.

The precept that periodic examination—and by this I mean breast self-examination by the patient and regular physical examination by a physician—is important in the early detection of breast cancer must be considered imperative for the public but imperfect for the patient. Like many maxims, this one is tempting in theory but thorny in practice. The diagnosis of breast cancer at the earliest possible time leaves something to be desired, even if examination is carefully carried out by an experienced physician with a high index of suspicion. Thus, there is a favorable opportunity for mammography—a hope in diagnosis which "springs eternal in the human breast."

Recently a newspaper notice appeared which read, "The volunteer fire department will blow the siren 15 minutes before the start of each fire." While awaiting the prospect of such a prophetic siren, either for firefighting or cancer-fighting, I have great expectations that the technique and precision of mammography soon will be improved to the point where it will help us detect small and silent breast cancers before they cast their shadows beyond us. We must make use of every available means to discover today what would be all too obvious tomorrow!

I am personally grateful to the special interest of my coworker and very good friend, Dr. Hugh Morrish, of the Radiology Department of the Johns Hopkins Hospital, for the opportunity of correlating and comparing our respective accuracy rates in the diagnosis of difficult breast diseases. This small series comprised only those women with difficult and deceptive diagnostic problems and excluded the run-of-the-clinic patient with a readily recognizable fibroadenoma, cyst, or obvious cancer.

The diagnostic accuracy of clinical examination alone (by a specialist) was compared with the diagnostic accuracy of mammography plus clinical examination (by a non-specialist). The results revealed a high degree of diagnostic accuracy by both methods.

In this particular series, I cannot say that the addition of mammography modified to any major extent my surgical management of these patients or the ultimate biopsy of their breast lesions. In my own opinion mammography will find its place as an important diagnostic adjunct, particularly in those high risk patients who have been operated upon for cancer of one breast (survey of the opposite breast after mastectomy), patients with a strong family history of cancer, women with multiple recurrent benign breast tumors, and in certain cases when it is expedient and prudent to "beware of the ample bosom."

I have had no personal experience with thermography. The premature publicity and extravagant claims which have appeared in the lay press have seriously impaired the reputation of the procedure. This ill-advised notoriety has caused a great deal of embarrassment and concern to clinicians whose patients are clamoring for the miracle of this nonexistent divining rod. It is difficult to persuade some patients that thermography is not yet generally available nor is it likely to be the "cure-of-the-month."

Mammography, on the other hand, has excellent prospects for more accurate definition by improved instrumentation. This intriguing image is not infallible but will find an increasingly important place in our diagnostic armamentarium as an adjunct to physical examination. Until then, however, we must continue to place our faith in surgical biopsy and accept the shadow for the substance with considerable restraint and reservation. In a recent editorial in the *American Journal of Radiology,* McDonald and Thomas[8] state, "There are still many breast cancers, some of which are easily palpable and clinically evident, that cannot be diagnosed by mammographic examination on present criteria."

Castration

The third topic of timely importance in the total treatment of breast cancer is that of prophylactic versus therapeutic castration. In premenopausal patients with primary breast cancer, is it wise to perform "prophylactic" castration at the time of mastectomy, or is it wiser to postpone this procedure for a later time when you may need it most? This is indeed the doctor's dilemma!

It is obvious that ovarian hormones have a profound effect upon the natural history of some hormone-sensitive breast cancers. A comprehensive review[7] of the medical literature reveals that about 25-35% of premenopausal patients benefit from therapeutic castration. This palliative benefit is unpredictable and time-limited. The wide range of difference in reported results depends to some extent upon the personal optimism of each investigator (there is a natural, built-in bias in all of us which inclines us toward labeling some geese as swans).

Therapeutic castration may greatly reduce estrogen excretion in premenopausal patients, but this is not always associated with an objective or subjective clinical remission. Conversely, clinical improvement may occur with only a minimal change in measurable estrogen levels. There are no prophets of prognosis to foretell which patients will respond to therapeutic castration and which patients will not. The caprice of this response is unpredictable—easy to see, but hard to foresee.

In the dogma of cancer education there is the proverbial dictum that delay breeds danger. Therefore, prophylactic castration done as an ancillary procedure at the time of mastectomy should instinctively enhance the survival time and increase the survival rate. A controlled clinical trial of prophylactic castration (by means of radiation) in patients selected at random was started some years ago in England by Paterson and Russel. The results have recently been reported by Cole.[1] The trend in survival rates favors an artificial menopause at the time of initial breast surgery, but the figures fall short of statistical significance. On the other hand, the cooperative clinical trial of the Surgical Adjuvant Breast Project of the National Cancer Institute, U. S. Public Health Service, has observed a rigidly controlled, random series of patients castrated by means of surgical oophorectomy. In this study group, followed thus far over a one- to four-year period, the preliminary results indicate NO significant trend in the recurrence rate between women receiving prophylactic castration and the control group of women who were not castrated at the time of radical mastectomy.

The decision in this dilemma of therapeutic versus prophylactic castration is difficult. No prudent person would venture to be dogmatic regarding the best treatment policy with the evidence presently available.

Yet, "When desperate ills demand a cure, distrust is cowardice and prudence folly" (Johnson). Decisions must be made daily and treatment cannot be dissipated by delay. I would recommend that prophylactic castration be used only in those premenopausal patients having an advanced stage II breast cancer at the time of radical mastectomy. In prognosis the "iceberg effect" of numerous axillary node metastases strongly suggests the possibility of more widespread subliminal cancer dissemination even though it is not clinically discernible. This is, in effect, therapeutic castra-

FIVE YEAR SURVIVAL RATE FOR BREAST CANCER TREATED AT THE JOHNS HOPKINS HOSPITAL BY THE HALSTED RADICAL MASTECTOMY

STAGE	1935-40	1941-45	1946-50	1951-56
LOCALIZED	64%	71%	66%	84%
REGIONAL	32%	34%	41%	42%
TOTAL	44%	46%	52%	62%

Fig 2
Five-year survival rate (crude) showing improvement in results over sequential time periods.

tion at an early time. With careful clinical consideration of the emotional stability and psychologic status of the patient, I would favor oophorectomy for those women with stage II disease under 40 and radiation castration for those women over 40, as well as for those postmenopausal women having a high estrogenic index on the vaginal cytogram. *For all other patients I would reserve castration for therapeutic purposes.* However, I would carefully caution all premenopausal patients to avoid pregnancy for a three-year period after mastectomy, and I would warn them against the use of oral contraceptives which contain estrogens.

The pleasant irony of Joseph Hilaire Pierre Belloc may be paraphrased to sum up our current confusion and concepts concerning castration in the treatment of breast cancer:

The Doctors, who ought to know,
Assure us that this might be so . . .
Oh! let us never, never doubt
What nobody is sure about.

Treatment

The fourth facet of this subject concerns the continuing controversy over the best surgical treatment of breast cancer. There are fierce personal passions which are "strongly prejudiced in favor of whatever is countenanced by antiquity, enforced by authority, and recommended by custom." Thus, although radical mastectomy has been our rampart of preservation for more than 70 years, there are equally strong convictions in favor of simple mastectomy on the one hand and super-radical or extended radical mastectomy on the other. It is quite obvious that although the routine Halsted radical mastectomy is still regarded as our treatment of choice in operable breast cancer, the omnipotence of this procedure over simple mastectomy (with or without radiotherapy) or super-radical mastectomy remains to be decisively demonstrated. Statistical proof of this superiority is still entirely lacking.

There is no doubt, of course, that earlier diagnosis and earlier treatment tend to increase the survival span in breast cancer merely by beginning the count-down at an earlier time. Thus, as long as cancer education, breast self-examination, and cancer detection continue to result in earlier and still earlier diagnosis, then that study which reports the most recent series usually will show the best survival rate (fig. 2). This may account for the paradox of breast cancer whereby the more recent survival rates show improvement over successive and sequential time periods despite the uniform and level trend of national and international mortality rates. The number of breast cancer deaths per 100,000 women has not declined in this country during the past 30 years. Although there may be varying trends in each age group[6] the total age-adjusted mortality from breast cancer (in females) in the United States was 23.8 per 100,000 population in 1930 and 24.3 per 100,000 population in 1959-61.

A careful and critical review of recent 10-year survival rates, instead of five-year survival rates, may give us a more reliable index with which to compare the effectiveness of various treatment

SURVIVAL RATES FOR RADICAL MASTECTOMY BY EXTENT OF DISEASE

Treatment	Negative Nodes			Positive Nodes			Unknown			Total	
	No.Pts.	Survival %		No.Pts.	Survival %		No.Pts.	Survival %			
		5 yrs	10 yrs		5 yrs	10 yrs		5 yrs	10yrs	5 yrs	10 yrs.
Radical Mastectomy	177	84	64	192	42	30	1	100	100	62.3	48.7

Fig 3

Crude five- and 10-year survival rate for breast cancer treated by radical mastectomy at the Johns Hopkins Hospital.

methods. Kaae and Johansen[5] have reported the results of two random and comparable series, including all new cases of breast cancer admitted to the Radium Center in Copenhagen since 1951. One group was treated by simple mastectomy and postoperative radiotherapy; the other group was treated by extended radical mastectomy. The comparative crude 10-year survival rates were 44% and 42%, respectively. Despite these widely differing treatment techniques, the 10-year results were almost identical.

The most recent report of McWhirter[9] from the Royal Infirmary of Edinburgh indicates a crude 10-year survival rate of 46% for 1,429 operable patients treated by a simple mastectomy and x-ray therapy. During this same period, the relative 10-year survival rate for radical mastectomy at the well-known M. D. Anderson Hospital[2] was 46.9%, and at the Johns Hopkins Hospital, the most recent (1951-56) crude 10-year survival rate for radical mastectomy was 48.7% (fig. 3). Devitt and Beattie[3] have recently reported the results of treatment of breast cancer at Civic Hospital Division, Ottawa Clinic of the Ontario Cancer Foundation in Canada between 1946 and 1957. The crude 10-year survival rate for radical surgery was 41% and for conservative surgery 38%. Conservative and radical surgery seemed to be equally effective when the crude survival rates and local recurrences are considered.

Thus, "though all things differ, all agree." There certainly seems to be a striking similarity and surprising uniformity of survival rates in most comparable series regardless of type of treatment or method of mastectomy. In celebrating our therapeutic triumphs are we merely measuring those "curable" cancers which grow locally or grow slowly without early spread of distant metastases? Whereas the five-year survival rates are generally similar, the 10-year survival rates are surprisingly uniform and almost identical when the extent of disease is comparable.

It is quite obvious that further comparisons between individual series of patients differing in time of treatment, case selection, and extent of disease will never resolve our basic differences of clinical opinion. The most effective method of evaluating different methods of treatment is by the organization of a large scale clinical trial. We owe a debt of gratitude to our British colleagues for their pioneer efforts in initiating these suitable studies. A carefully controlled clinical trial is currently underway in southeast Scotland. Participation is in accord with a very precise protocol, and patients are randomly allocated for 1) radical mastectomy or 2) simple mastectomy and radiotherapy. Ultimately these results should permit a valid comparison between two vastly different treatment methods for operable breast cancer.

In the design of a clinical trial there must be no conflict of moral or ethical conduct on either side of the study. If the consensus of existing knowledge indicates that the methods of treatment that are being clinically compared are *equivalent,* then our professional ethics are justifiable and the therapeutic trial morally proper.

There is an urgent need for a large and carefully controlled clinical trial to compare the effects and results of alternative methods of treatment for breast cancer. The protocol of this clinical trial should include comparisons between

radical mastectomy, simple mastectomy, super radical mastectomy, as well as such adjuncts as castration therapy, radiotherapy, and chemotherapy. Only by a carefully designed clinical trial of this kind can we determine the best treatment policy for each patient. In this critical matter we can no longer afford to be "sheep in credulity, but wolves for conformity."

Clinical opinion varies widely as to the best treatment policy for each patient, ranging from total surgical nihilism to the heroic efforts of super-radical surgery including supraclavicular dissection and simple mastectomy on the contralateral side. While recognizing the need for orthodoxy in our accepted practice, we must be receptive to the proposals of surgical heterodoxy. The wisdom of St. Paul combines progress with tradition —prove all things and hold fast that which is good.

550 N. Broadway
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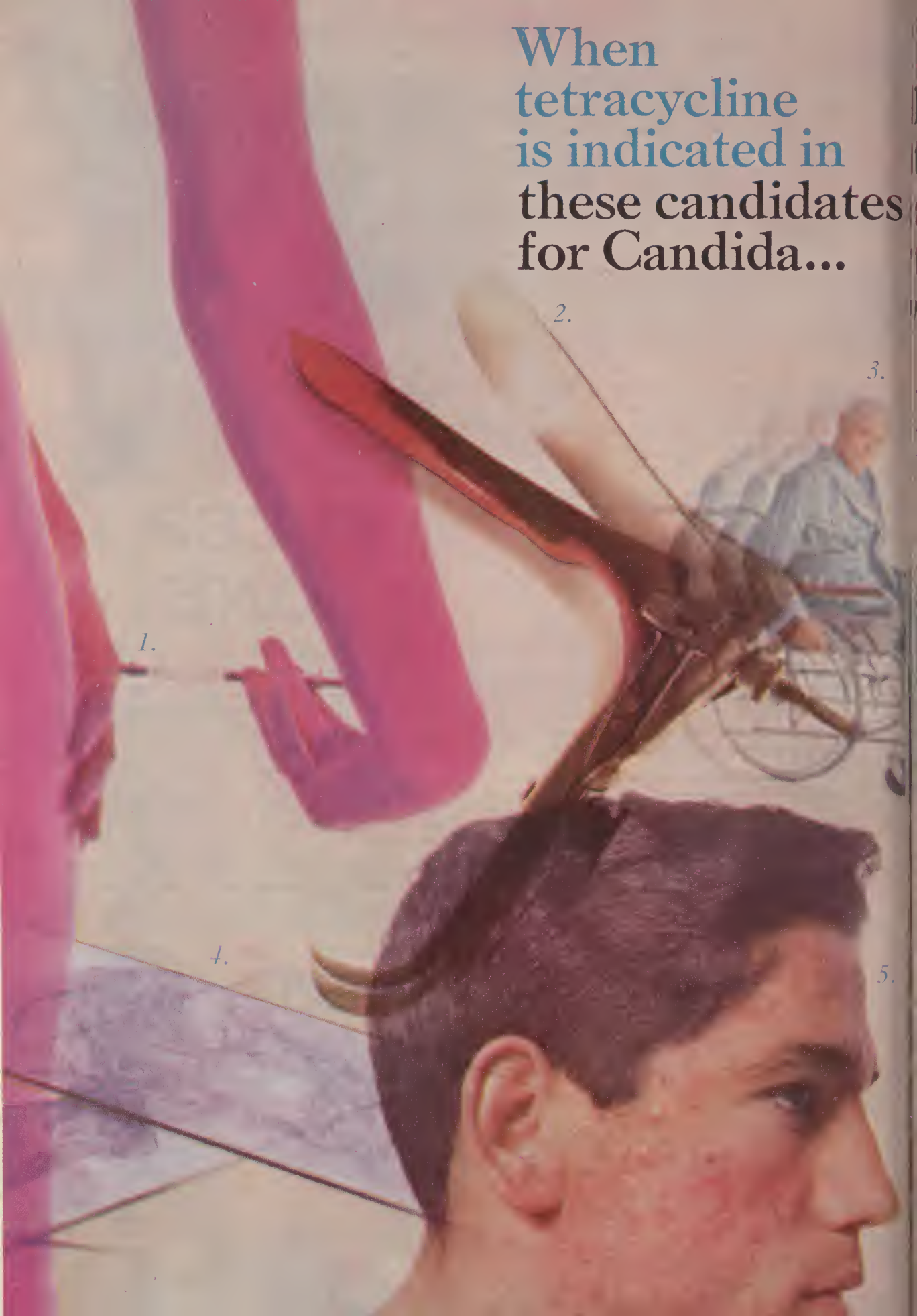
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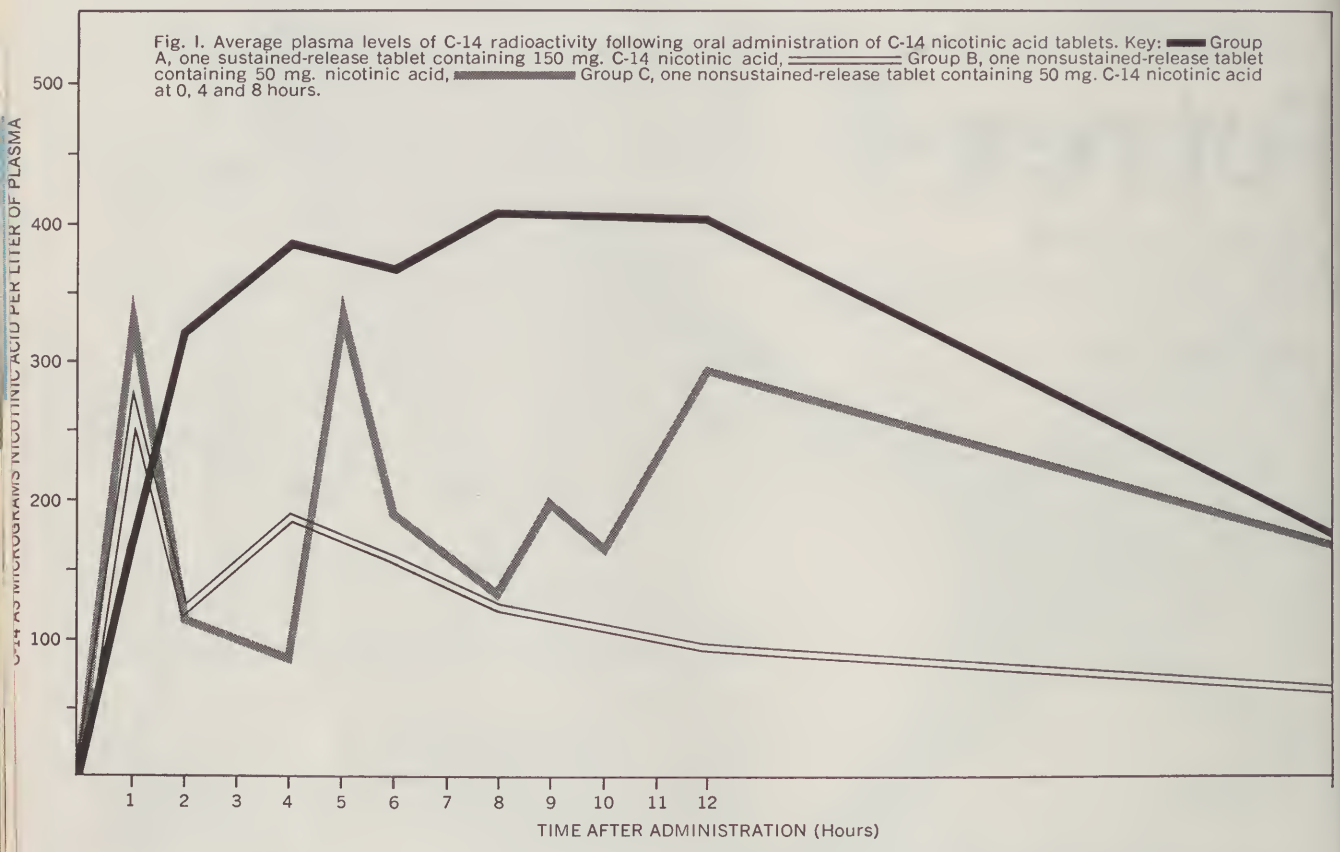
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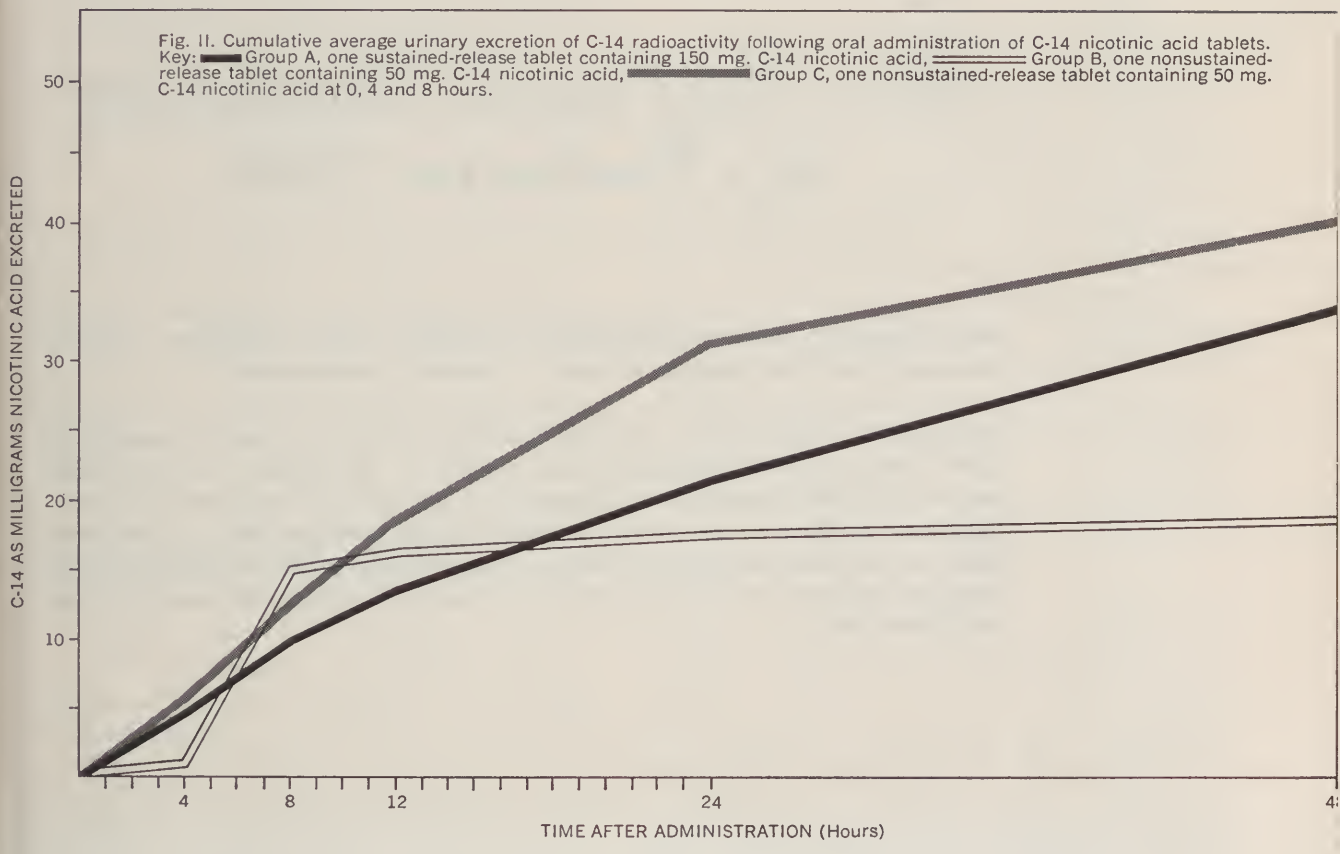
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Use of the Physical Examination in a Psychiatric Clinic

What happens when an outpatient psychiatric clinic establishes a policy requiring each new patient to have a physical examination?

The Mental Health Study Center, in Prince George's County, instituted such a policy and then investigated its effects on the patients, on the clinic, and on the physicians in the community. The clinic found that the new requirement did not deter patients seeking help, that the delay in rendering clinic services was slight, that 45% of the examinations revealed positive findings, and that it created better communication with the physicians in the community.

FORTUNE V. MANNINO, PhD
HAROLD W. WYLIE, JR., MD

The Mental Health Study Center, a branch of the National Institute of Mental Health, was established in Prince George's County, Maryland, in 1948 as a mental health clinic. One of its major functions has been the operation of a psychiatric outpatient unit, which has served the residents of Prince George's County for 15 years. While continuing to maintain its clinical functions, the Center has in more recent years placed increasing emphasis upon research and demonstration activities.

Several years ago the professional staff became concerned that in many instances there was little or no knowledge about the physical status of patients who were referred to us by various professional persons in the county. Since we believe knowledge of a patient's physical condition to be a necessary part of a full and complete psychiatric evaluation, we decided to include a physical examination as a routine part of clinic admission procedure. The director of the Study Center, along with other physician members of the staff, designed a brief physical examination form to be completed for all patients accepted by the Study Center for psychiatric service.

The following procedure was established:

From the Mental Health Study Center, Adelphi, Md.

When a patient, having already been accepted for service through referral from a professional source in the county, calls the Study Center to discuss arrangements for his initial appointment, he is told of the necessity for a physical examination. He is told that the form will be sent to him, along with a letter addressed to the physician explaining the necessity of the examination, and a self-addressed, stamped envelope. The form is to be taken to the patient's physician of choice, completed, and returned to the Center, whereupon the clinic's receptionist contacts the patient for his first appointment.

This basic procedure has continued unchanged since its adoption. Exceptions to its use are rare. It has been waived for emergencies, for brief psychiatric examinations as part of consultation, and occasionally when the referring source is a physician or medical agency which already is familiar with the patient's physical condition. Few patients have objected to having the examination. In general, we have found the policy to operate efficiently.

This does not mean that we did not have certain questions which we wondered about, in spite of the apparent efficiency with which the procedure worked. Four particular areas concerned us, which we decided to investigate:

1. The first had to do with the effect of the physical examination requirement on our patients. Did some patients tend to regard it as an obstacle, ie, one additional hurdle to overcome before receiving help? If so, did many patients who might otherwise have availed themselves of our services fail to do so because of this requirement?

2. The second question was whether or not the physical examination further delayed the patient in receiving clinic services. Since we had no idea of the time interval between a patient's call to us and the return of the completed examination form, we did not know to what extent the requirement caused a delay in the services offered.

3. Next, we were curious as to how often physical examinations revealed other than negative findings on our patients. Negative findings in and of themselves are of sufficient value to warrant their use, but we also wanted to know how often clinically significant findings came to light.

4. Finally, we wondered how the physicians in the community reacted to the physical examination form. We had hoped that the form would inform them about the Study Center as a medically-oriented psychiatric agency and would provide the Center staff with an opportunity to communicate with the physicians about specific situations whenever appropriate; however, the extent to which this actually occurred was not known.

Method

To answer these questions, several related investigations were undertaken. First, to explore questions 1 and 2, we compared a group of patients which had not been exposed to the physical examination requirement with a group which had been so exposed. The first group comprised all patients who had been accepted for service during the 21-month period immediately prior to instituting the physical examination requirement, and the second group comprised those patients accepted during the 21-month period after institution of the new policy.

To find out how often information useful to the psychiatric staff was obtained from completed physical examinations (question 3), all completed examinations obtained during the 21-month period after the requirement was established were reviewed by a staff psychiatrist.

Finally, to learn whether this arrangement of obtaining physical examinations stimulated or increased contacts or perhaps reduced contacts between the Study Center staff and the community physicians, we checked the names of all physicians who returned completed physical examination forms to us with the names of physicians who had previously used the Center to request referrals or consultations. The primary intent here was to determine the number of physicians who began to contact the Center, ie, called about referrals or consultations,* after they had performed one or more physical examinations on our patients, and the number who either increased or decreased their use of the Center in this manner after having completed one or more physical examinations.

Findings

We found, first, that the physical examination

*Consultation as used here refers not to the customary practice of a physician reviewing and examining a patient for a fellow physician and then making specific recommendations, but rather to the much broader practice of discussing psychiatric issues as they may pertain to medical practice or a particular patient problem.

requirement did not increase the number of patient admission failures. The difference in the percentage of patients who called for service and then failed to follow through, before and after the physical examination requirement was placed in effect, was insignificant (17% before and 19% after). Hence, it appeared that patients did not view the requirement as an obstacle to help.

Second, we found that the average length of time which it took for patients to receive the physical examination form from us, have the examination completed, and the form returned was slightly less than two weeks. This surprised us; we had somehow believed that it took considerably longer to accomplish this procedure. Therefore, the physical examination requirement itself did not cause an unreasonable delay in the receipt of clinical services from the Center.

To our third question, a review of 99 completed physical examinations showed that 45% reported physical or historical findings with clinical significance. The study included only those findings of physical problems which could affect the clinical course of the patient as revealed by a report of physical abnormalities and/or report of diagnostic studies or medical treatment. For example, knowledge of physical abnormalities such as a femoral hernia, an enlarged thyroid, or active cervicitis was considered important to the professional staff. Similarly, descriptions of previous diagnostic studies, such as a bronchoscopy or an upper gastrointestinal series, and the history of previous medical and/or surgical treatment, such as a treated duodenal ulcer or a bilateral oophorectomy, were held to be of clinical significance.

This finding would appear to attest to the importance with which local physicians viewed the physical examination, as well as to the thoroughness of their work. Considering this along with the relatively short time in which patients completed the examination, one is impressed by the spirit of cooperation demonstrated by the physicians.

Finally, upon reviewing all physical examinations completed during the first 21 months of the new policy, we found that 69 physicians in the metropolitan Washington area had completed examinations on our patients. Of these, 34 had not had prior contact with the Center, while 35 did have previous contacts with the Center concerning consultation and/or referrals. Of those who had had no prior contact, 12 subsequently instituted one or more contacts concerning referrals or consultation. Of the physicians who had previous contacts with the Center, seven began contacting the Center more frequently after submitting one or more physical examination forms. Contacts by the remainder of this group continued with no noticeable change except in two cases in which the frequency of contact appeared to decrease. Therefore, of the total 69 cooperating physicians, 19, or 28%, either initiated or increased their contact with the Center after establishment of the physical examination requirement.

Conclusions

The experience at the Mental Health Study Center has shown that the physical examination requirement has not had an adverse effect on the patients applying for clinic services but has provided a method for better communication between the Center and the medical community. Although the examination requirement caused some delay in the patient's receipt of clinic service, this delay was relatively slight when compared with other factors which usually enter into the patient's waiting period. Moreover, in spite of this delay, there was no evidence to suggest that the physical examination requirement was an obstacle between the patient and the Center.

The policy requiring physical examination created a liaison between the mental health clinic and the physicians in the community. The importance of this liaison cannot be overstressed, since it acts to the mutual benefit of the clinic, the physician, and the patient. For the clinic, an opportunity to confer with the physician, who in many instances has a long acquaintance with the patient and his family, can provide valuable information and give us a better understanding of the patient's problem. The physician, who often maintains care of the patient during and after his clinic contact, gains an added understanding of the emotional implications of the patient's medical problem. Finally, the patient receives the benefit of cooperative medical care through receiving psychiatric treatment from a professional who is alert to his physical problems and through being cared for by a physician who is attuned to the emotional implications of his medical problems.

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Massive Doses of Ethamivan in Severe Phenobarbital and Tranquilizer Intoxication

A. A. SILVER, MD

Ethamivan (vanillic acid diethylamide), a relatively new respiratory analeptic agent, has been reported to be useful in the treatment of respiratory insufficiency[1-9] in chronic or acute respiratory disease and in combatting central and respiratory depression from excessive barbiturate administration.[9-15]

It is a restorative agent with a prime site of action at the medullary center, effecting respiratory stimulation and arousal. Secondary influences have been demonstrated by the restoration of heart rate and blood pressure to predepressed levels. In a dose-related manner, stimulation of the brain stem can ascend to reach cortical levels and produce generalized cortical excitation. By monitoring dose and rate of administration, selective respiratory stimulation may be activated, stimulated, and maintained in centrally depressed states.

Toxicity of sedative, narcotic, and hypnotic drugs is directly related to the degree of respiratory insufficiency or failure ultimately resulting in terminal vasomotor collapse, asphyxia, and death. Intensive efforts, in the absence of specific pharmacologic antagonists to the barbiturates, are directed toward maintaining adequate renal function. This report describes the management of a patient severely intoxicated with barbiturates solely by continued administration of the respiratory analeptic ethamivan. Once a patent airway was assured, this agent satisfactorily controlled respiratory activity, circulatory dynamics, and renal output.

CASE REPORT

A 65-year-old diabetic, white man was admitted to the Sinai Hospital on August 17, 1963. He had been unconscious for about 14 hours before admission. Three hours before admission, his business associate had found him in his office, unconscious, lying beside his desk. He had him removed to a nearby hospital emergency room, where the diagnosis of cerebrovascular accident had been proposed. The attending house officer

This is a case of a diabetic man with severe phenobarbital and meprobamate intoxication. Respiration was successfully maintained during six days of unconsciousness with massive intravenous doses of ethamivan. A total of 40.5gm was administered. The only side effect noted was the appearance of bullae secondary to induration at the site of intravenous injection. Follow-up studies of renal and hepatic function showed no evidence of toxicity from either the depressant or stimulant drugs.

had received erroneous information that the patient had left his home to go to his office earlier that day.

The patient's breathing was described as shallow, and he was reported to be deeply cyanosed upon arrival at the emergency room. Blood pressure was 108/60; pulse was rapid and weak. Oxygen was delivered via nasal catheter at a rate of 4-6 liters/min for 48 hours, and an intravenous infusion of 5% dextrose in water was given. Three hours after first being seen in the emergency room, he was transferred to the Sinai Hospital. Oxygen and IV fluids were continued during the transfer.

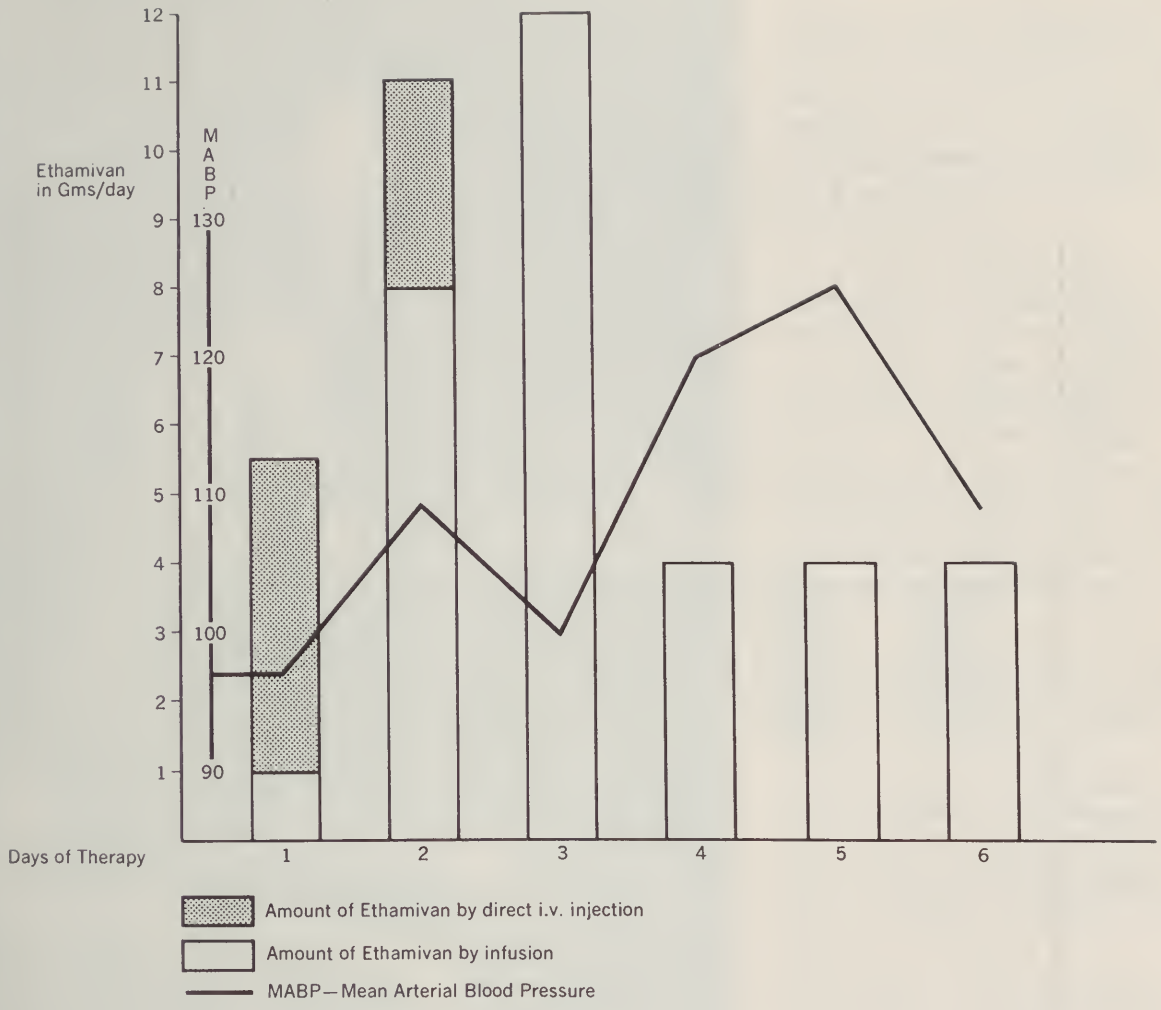
Upon arrival at the Sinai Hospital, the patient was comatose; he showed Cheyne-Stokes respirations, and the blood pressure was 110/60, falling rapidly to 80/60. There was no evidence of trauma; the DTR were depressed in all extremities; and the EKG showed left ventricular strain. He was given gastric lavage, tracheal suction, and nasal oxygen. Lumbar puncture revealed the spinal fluid to be clear and under normal pressure; chemical and microscopic examination of this fluid was normal. Hematocrit was 42.5; WBC, 12,000 with normal differential. Initial blood chemistries included: blood glucose, 210mg/100cc blood; blood urea, 32mg/100cc blood; CO_2, 26mEq/l, and electrolytes normal.

Fours hours after admission to the Sinai Hospital it was learned that the patient had left his home 13 hours before being found unconscious. This information, together with the spinal fluid findings and the clinical picture, led us to suspect barbiturate poisoning. Blood and urine were immediately obtained, and it was ascertained that the blood serum barbiturate level was 6mg/100cc blood, and the urine (by catheterization) showed a barbiturate level greater than 100mg/100cc urine, together with traces of meprobamate.

Ethamivan therapy was started immediately upon suspicion of barbiturate poisoning. On the first day of hospitalization, 5.5 gm of ethamivan was administered in the following manner: 500mg was given directly intravenously, and a continuous infusion of 5% dextrose in water was started with 1000mg of ethamivan added to 1000cc fluid, plus regular insulin to cover the dextrose. Immediately upon injection of the compound in the concentrated state (10cc ampul containing 500mg of ethamivan in 5% aqueous diethanolamine), respirations became deeper and the patient responded to pain stimulae. In the next six hours he received three doses of ethamivan by direct intravenous injection of 1000, 1500, and 1500mg each, to restore normal respirations. At this point the hospital's supply of ethamivan was depleted and approximately three hours elapsed before an additional supply was obtained. During the period without treatment, Cheyne-Stokes respiration reappeared and the patient did not respond to pain stimulae. When ethamivan was resumed, breathing again became normal and the patient again responded to pain stimulae.

On the second day of hospitalization, beginning at 1 AM, he received 11gm of ethamivan; 2000mg was given every six hours by continuous infusion in 1000cc of dextrose in water. He also received two doses of 1500mg directly IV when Cheyne-Stokes respiration reappeared. At 10 PM of the second day of hospitalization, several bullae, 1 to 2cm, appeared at the site of infusion. Temperature rose, and 500mg oxytetracycline was added to each 1000cc IV fluids every six hours for 24 hours.

On the third day the patient received an additional 12gm of ethamivan similarly administered. He began to react more to pain stimulae; he opened his eyes and became somewhat restless. On the fourth day adequate control was maintained with 4gm of ethamivan divided in doses of 2000mg each by continuous infusion with 1000cc of dextrose in water. On the fifth day he began talking incoherently; again two doses of 2000mg were given by continuous intravenous infusion. On the sixth day he was able to swallow liquids; breathing became normal, and he was maintained on the continuous IV 5% dextrose in water with 1000mg ethamivan every six hours. On the seventh day he was able to eat the full diabetic diet; IV fluids and ethamivan were discontinued. He was coherent and was able to relate the full details of his attempted suicide. He disclosed that he had taken 30 1.5 grain tablets of phenobarbital and an undetermined amount of meprobamate (more than 100, 400mg tablets, approximately 48,000mg). On the eighth day psychiatric treatment was started, and on the seventeenth day he was discharged to his home and outpatient psychiatric care.

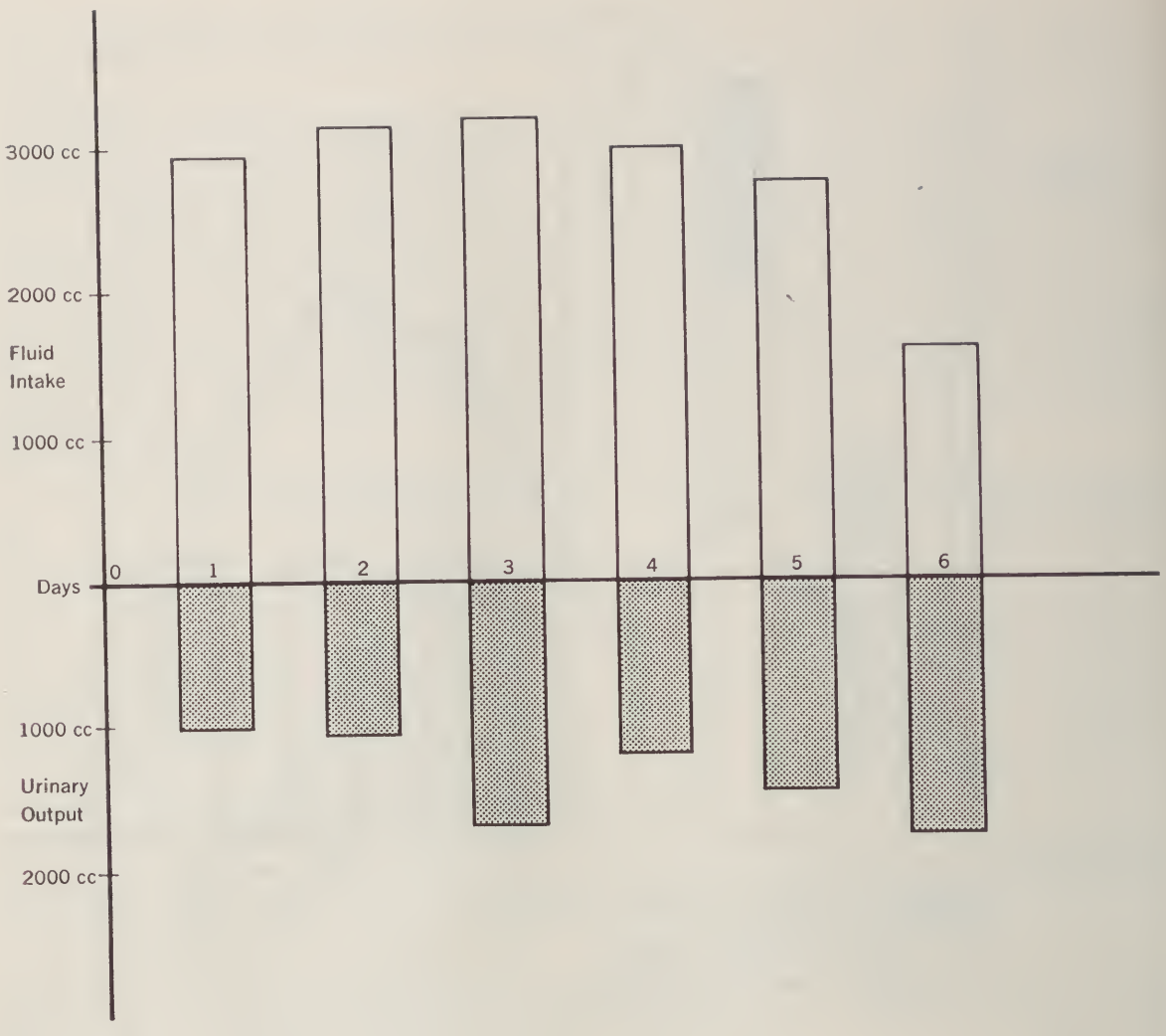


DISCUSSION

In this case of severe barbiturate and meprobamate intoxication, the patient was first seen in coma and was managed through to complete recovery. A patent airway, supplemental oxygen administration, and ethamivan constituted the therapeutic regimen. At least in this case, the need for ancillary measures never arose. In fig 1 doses of ethamivan on a daily basis are recorded and divided into modes of administration. The duration of supplemental oxygen administration is not shown; this was administered continuously for the first and second hospital day at 4-6 liters/min via nasal catheter. Of vital significance is the level of mean arterial blood pressure and the urinary output maintained as a response solely to the administration of this respiratory stimulant and, therefore, plotted in fig 2. Observations of respiratory activity are reported in the text. Except for rate which was deemed adequate, no other monitoring of this parameter was performed; clinical estimates seemed valid and are supported by the outcome.

CONCLUSION

Ethamivan is safe and effective when given intravenously in massive doses over an extended period of time. It may be used concomitantly with glucose, insulin, tetracycline, and oxygen in the management of barbiturate and tranquilizer intoxication. One must use extreme caution to prevent extravasation of infusion material at the site of injection, since the induration which we encountered produced severe pain for several



days. Although unusually high doses of ethamivan were used to support respiration in this case, we encountered none of the side effects previously reported (sneezing, itching, muscular twitching, coughing, etc.), and its administration was continued until no longer required.

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GENERIC AND TRADE NAMES OF DRUGS

Ethamivan—*Emivan*
Meprobamate—*Equanil, Miltown*
Oxytetracycline—*Terramycin*

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EATING PATTERNS OF OBESITY

A study of recorded diets of obese patients in an out-patient clinic.

IAN R. ANDERSON, MD
MERRILL I. BERMAN, MD
Co-directors, Anti-calory Clinic

The dangers and complications of obesity are almost as well known and as frequently heralded as are the dangers of excessive smoking or drinking. Obesity decreases life expectancy. Even rats of normal weight outlive those who are overweight.[1] In humans, life expectancy decreases as the degree of overweight increases.[2, 3] Because epidemic obesity appears to be related to economic stability and overabundance, the United States has been beseiged, both in the lay press and in medical journals, with diets, drugs, and combinations of each designed to reduce the more corpulent members of our society.

In this struggle for an answer to obesity and its many-faceted problems, there has been a recent upsurge of investigations into weight reducing through lower caloric intake. Other investigations have sought the reasons why an individual is and remains obese as related to his basic eating patterns. Recent work with rats has shown that when rodents are allowed to eat ad lib (as is their usual habit) they will retain their normal weight; however, when they are exposed to food for a limited number of hours a day and must consume their total daily intake during this artificial period, there is initially a weight loss followed by a rapid gain to levels above their normal weight. There appears to be a rather intriguing resultant metabolic error produced in these studies with an increase in lipogenesis during the "stuff and starve" program which, teleologically, may be interpreted as an attempt to store, during the limited eating period, sufficient calories for 24 hours by converting glucose and carbohydrates into fatty acids for more economical storage of calories for future use.[4] This apparent metabolic defect has been postulated to lie either in a rearrangement or derangement of the satiety center in the ventrolateral hypothalamus or a possible change in the enzyme systems responsible for adipose tissue deposition and fatty acid metabolism, or even in a combination of these.[5]

This work on rats has been interpolated to humans and is demonstrated by patient eating patterns. The obese person supposedly is one who often eats no breakfast or lunch and subsequently eats a rather large dinner with continual snacks after the evening meal. These people also may manifest the "night-eating syndrome" with apparent loss of satiety and associated insomia.[4]

In our clinic, we have found some data which may fail to substantiate some of the aforementioned theories and their conclusions.

METHODS

The Anti-calory Clinic was established in September, 1962. It is an out-patient clinic which is open to the citizens of Baltimore between the ages of 17 and 50 regardless of sex or socio-economic conditions. We have processed more than 100 patients thus far with gratifying results in 80%. The clinic meets weekly, and the initial testing period for weight reduction is three months. After this three-month period is completed, the patient may continue to attend the clinic if he wishes to do so. Each patient is weighed in and his actual recorded diet is reviewed by one of the two clinic physicians. A complete history and physical examination is obtained on each patient. Laboratory studies include a complete blood count, a fasting blood sugar, a protein-bound iodine, and several hepatic function tests. Each patient is instructed to faithfully record, as ingested, each portion of food consumed. This actual diet is reviewed each week with a physician who points out the nutritional

errors and suggests methods of taking in less calories while attempting to improve nutritional content. It is with these personally-recorded diets that this paper deals.

RESULTS

From the patients processed so far, we have been unable to find any who would fit into the "stuff and starve" concept. From our analysis of the initial diets handed in and from subsequent diets which are kept continuously throughout the clinic program, we have found that practically all the patients eat at least two meals a day. If an entire meal is skipped, a snack is often consumed two hours later.

Eighty-two per cent of the patients eat breakfast, with 54% of this number eating more than 700 calories. Most of the patients (72%) eat lunch, with occasional exceptions who attempt to lose weight by skipping this meal. The last scheduled meal of the day is usually the largest; however, between-meal snacks begin some time after breakfast and gain full force after lunch, with 54% having had the first snack before lunch and 76% having had at least one snack after lunch. Ninety per cent of the patients continue to eat after dinner, but only 38% of the patients give a history of insomnia and the "night-eating syndrome" in its mildest form.

In subsequent diets which are recorded and reviewed, we have found that the between-meal snack usually does not disappear but rather changes in character as the patient receives more nutritional guidance. Since the patients are encouraged to increase their intake of protein, we find snacks consisting of meat products replacing cake and candy. Some patients use unflavored gelatin in a fresh fruit juice or skim milk. The most difficult snack patterns to break are the after-dinner snack the "company" type of snack, when one must be a good hostess or guest and accept the customary offerings; however, even these snacks gradually diminish or are altered for less calories and more nutritious items.

SUMMARY

After one year and more than 100 patients, we believe that the clinic population of our Anticalory Clinic has much to offer in the investigation of human eating patterns of obesity as opposed to those of rats. Our patients 96% of whom are women between the ages of 20 and 50, have faithfully (we hope) recorded their actual and, at the beginning of the program, customary dietary intake. All such diets have an overabundance of calories and more carbohydrates and fats than recommended for proper nutrition; however, in contrast to the popular idea that the obese patient skips meals during the day and eats mainly at night, most of our clinic population eats three meals a day with frequent snacks between meals and the heaviest intake at night. In most cases, this evening eating pattern appears to be a manifestation of our social climate, with television and other sedentary activities as contributing factors, rather than some hypothalamic or enzymatic abnormality. Our study suggests that the obese person does not indulge in a "stuff and starve" program but rather in a one-meal-all-day-long pattern which not only produces but maintains the corpulent state.

It would appear that the overweight person must still depend on the usual methods of losing weight; ie, 1) take in less calories, 2) change his eating habits to include more nutritious foods, and 3) be motivated enough to lose weight to seek help through an out-patient clinic or other medically-supervised program. We believe that our clinic population is typical of the corpulent population in this country who seek medical advice. This is not to dispute the possibility that some obese patients may have a metabolic defect in their lipogenesis or in their hypothalamic apparatus, but whether this is cause or effect is yet to be proven.

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Baltimore, Md. 21201
(Dr. Berman)

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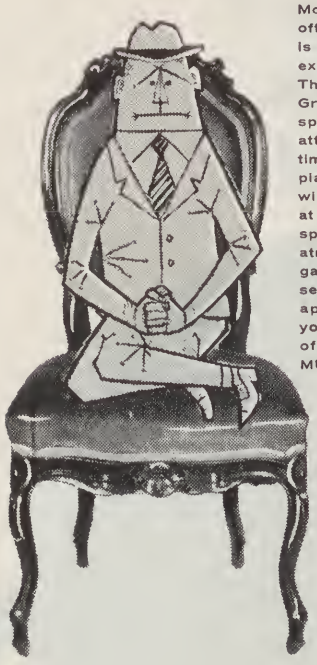
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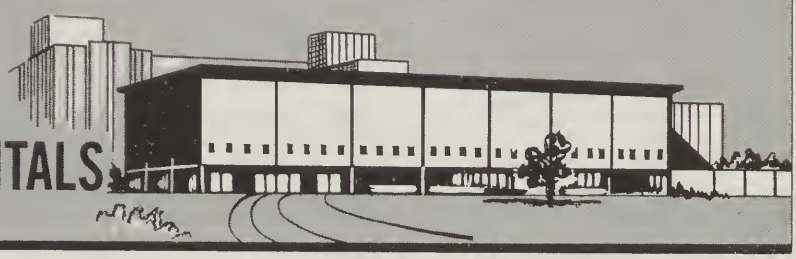
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HISTORY OF THE BALTIMORE CITY HOSPITALS

BY DOUGLAS CARROLL, M.D.



Chapter 4.—The Almshouse at Calverton: Contemporary Pictures and Comment (1822-1865)

A number of charming drawings of the Almshouse at Calverton have come down to us. Figure 1 shows the Almshouse and inmates. Figure 2 is the ground plan of the Almshouse showing the ice house, the dead house, and the male privy lined up along the back wall with open sewage passing out into the meadows. Figure 3 shows the medical records of patients admitted in June of 1823.

Three contemporary descriptions of the Almshouse at Calverton follow. The third, published in 1844, goes beyond description to draw the conclusion that life at the Almshouse is too easy on vagrants. The fact that the Almshouse had only 600 inmates is attributed to the easy access to the west and the presence of slaves.

1. LATROBE, JOHN HAZLEHURST B.: *Picture of Baltimore,* p 150-153, 1832.

The centre building of this establishment, originally the dwelling of a private gentleman, is very large, and was erected after a design of R. C. Long, esq. It is now occupied by the overseer, physicians, & c. The front is 55 feet, and the depth 53. There are two wings, 130 by 40 feet each, of two stories, and a basement occupied by the paupers, and connected with the centre building by covered galleries. The whole front 375. A bath-house, wash-house, bake-house, and spacious court yard, are in the rear.

To this important institution is attached a good body of land on high ground and having a stream of water running through it. The poor of the county and city are sent to this establishment, and such as are able are made to work and receive credit for their labour as an offset against the cost of maintaining them. For this purpose, the farm on which the Almshouse is situated affords admirable opportunity. Few places in the neighborhood of Baltimore are more worthy of notice than the Almshouse.

There are twelve ward managers for the poor, and four trustees, under the care of the last of whom, is the Almshouse more immediately placed.

The following extract from the report of the Trustees of the Poor for 1831, exhibits the situation and character of the institution at this time:

"There were admitted into the house during the year, ending the 30th April, 1831, including 21 births, 1160 paupers; discharged, 387; bound, 30; deceased, 237; eloped, 447; leaving, 567 paupers, including those before in the house.

"Although the number of admissions, into the Almshouse, from the increase of population and other causes, has been gradually augmenting, the trustees are gratified to find, on referring to their reports for several years past, the demand for the ensuing year, upon the funds of the Mayor and City Council, to be less than that of preceding years.

"The expenditure per head, for supporting the poor, for the year ending the 30th April, 1826, was 37 dollars 63 cents, and same has been gradually reduced, until, for the year ending the 30th April, 1831, it amounted only to 25 dollars 72 cents per head. In this estimate are included all charges for farming expenses, permanent improvements on the estate, repairs, salaries, and contingencies, excepting only the interest on the Calverton debt.

"The reduction of expenditure is principally to be attributed to the increased productiveness of the farm, and to the quantity and value of the articles made up, or manufactured, in the house, furnishing not only supplies of food, clothing, & c., for the use of the institution, which would otherwise be purchased, but affording a considerable quantity for sale. The carpenter's and other mechanical work done by the paupers, forms also a large item in the avails of the establishment, which serve to lessen the demand upon the public funds.

"Besides reducing the cost of maintaining the paupers, the requisition of some sort of labour from such as are able to work, has a still more beneficial and important effect, as it tends to prevent an increase in the house, of the idle and lazy, who are able to maintain themselves.

"The trustees have frequently adverted to the fruitful source of nearly all the pauperism that comes under their notice, the intemperate use of ardent spirits. They have now the satisfaction, however, to say, that the rule of



Fig 1

Alms House, Calverton, from Latrobe, J.H.B.: Picture of Baltimore, 1832.

the institution forbidding the use of any vinous, spiritous, or fermented liquor, as an article of diet, has been strictly enforced, and the late harvest at the farm, which employed several hands, was secured without any such allowance."

2. VARLE, CHARLES: *A Complete View of Baltimore*, 3:90, 1833.

The trustees of the poor of Baltimore county, were incorporated in the year 1773. They formerly occupied, for the accommodation of the poor of the city and county, a neat shewy building, situate in the upper part of North Howard Street, but about ten years past, finding this building was too small, they purchased "Calverton," the county seat of Dennis A. Smith, with its splendid mansion, to which they added two wings of 130 by 40 feet each, and other necessary out-buildings, and thereby formed the present large and elegant Almshouse, which, in point of extent, convenience, and beauty of location, certainly is not surpassed by any similar establishment in the United States. It is situated about 2½ miles from the court-house, in a north-western direction, on the Franklin M'Adamized road, and is well worthy of being visited by strangers. The expense of the purchase and improvement of this place amounted to $100,000. Its con-

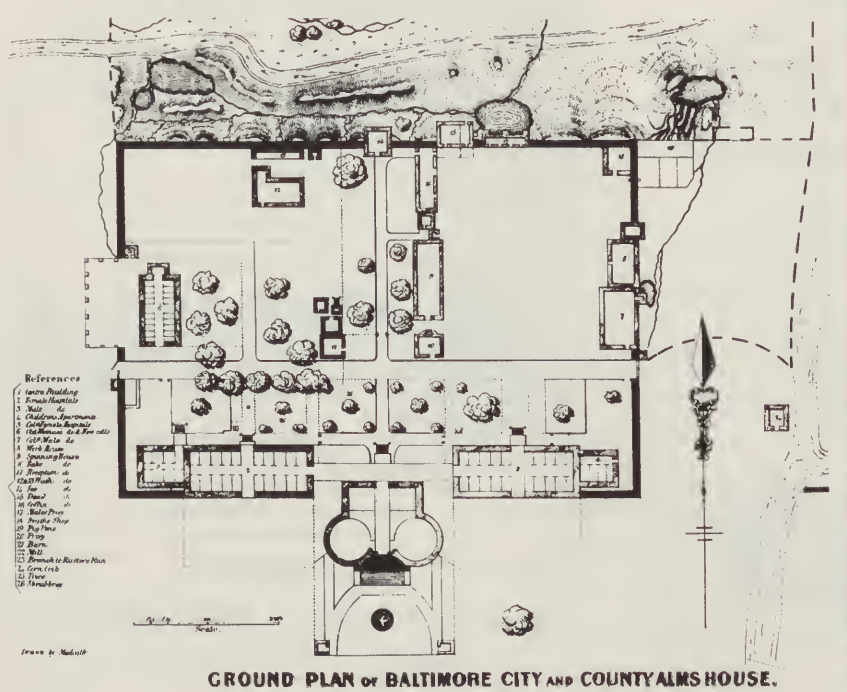
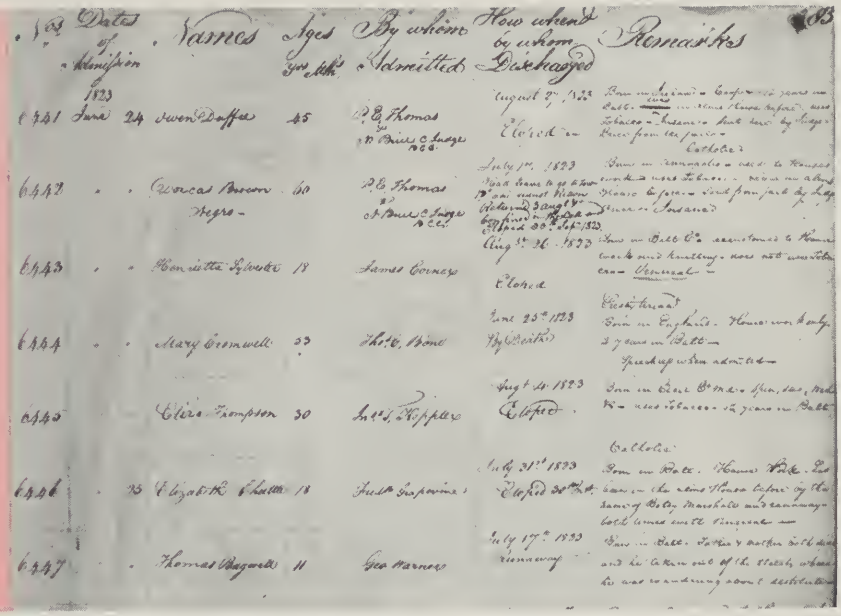


Fig 2

Ground Plan of Baltimore City and County Almshouse at Calverton, from T. H. Buckler: A History of Epidemic Cholera. Baltimore, 1851.



No.	Dates of Admission 1823	Names	Ages Yrs. Mths.	By whom Admitted	How when & by whom Discharged	Remarks
6441	June 24	Owen Doffee	45	P. E. Thomas per W. Bailey C. Judge No 6	August 9th 1823 Eloped	Born in England — Emigrated 20 years ago — Baltimore — Labourer — Parents dead — Never married — Left work on account of sickness — Left from Asylum — Catholic
6442	" "	Dorcas Brown Negro	60	P. E. Thomas per W. Bailey C. Judge No 6	July 1st 1823 Good home to go when in want Returned Eloped Returned Sundry times Confined in Hospital from 30th July to 1st Aug 1823	Born in Annapolis — used to Farming — never married — never was absent from Asylum 6 years — Left from fear of Imprisonment — Insane
6443	" "	Henrietta Sylvester	18	James Cooney	Aug 31st 1823 Eloped	Born in Balt Co — accustomed to House work and knitting — never was sick — Protestant — Venereal —
6444	" "	Mary Cromwell	33	Visit. Phys.	June 25th 1823 By Death	Born in England — House work only — 3 years in Balt — Friendless when admitted — Protestant
6445	" "	Clara Trompton	30	Visit. Physician	Aug 4th 1823 Eloped	Born in Balt Co — Mar. — Spin. Knit. Milk — never sick — 12 years in Balt — Catholic
6446	" 25	Elizabeth Chatten	18	Visit. Physician	July 31st 1823 Eloped 30th Inst.	Born in Balt. — House Work — Has been in the same House before by the name of Betty Marshall and runaway — both times until Pregnant —
6447	" "	Thomas Bagwell	11	Geo Warner	July 17th 1823 Runaway	Born in Balt. — Father & mother both dead — he is taken out of the Streets, where he was wandering about destitute —

Fig 3

Almshouse admission book for June, 1823, showing age, reason for admission, place of birth, religion, past work record, diagnosis, and disposition.

cerns are managed by five trustees, who at present are Joseph Cushing, John Kelso, Frederick Schaeffer, Joshua Hutchins, and Archd. Sterling.

To convey some idea of this institution, I have extracted the following statements and table from the records of the mayor's office, viz.

There were in the house April 30, 1830, paupers		558
And there were admitted during the year ending April 30, 1831, including 21 births, paupers		1,160
	Making	1,718
Of which, in the same period, there were:		
discharged	387	
bound out	30	
deceased	287	
eloped	447	1,151
Leaving in the house		567

Statement of the habits of the paupers admitted into the house in the year ending April 30, 1831, to wit:		
Adults of temperate habits	27	
Of intemperate habits	960	
Whose habits in respect to temperance were unkown	19	
	1,006	
Children of temperate parents	18	
Of intemperate parents	119	
The habits of parents unknown	17	154
		1160

Places of birth of the paupers admitted during the said period, viz.

Almshouse	21	Rhode Island	3
Baltimore County ...	86	Connecticut	2
Baltimore City	200	New York	17
Eastern Shore of Maryland	107	New Jersey	4
Other parts of Maryland	120	Pennsylvania	53
Canada	1	Delaware	5
Maine	12	District of Columbia	8
Massachusetts	3	Virginia	30
North Carolina	1	Spain	1
South Carolina	2	Portugal	2
West Indies	4	Germany	44
East Indies	2	Holland	1
England	51	South America	2
Ireland	349	Africa	2
Scotland	15	Unknown	9
France	5		1160

3. GODLEY, JOHN ROBERT: *Letters from America,* 2:177-178, 1844.

I have paid a visit to the Baltimore Almshouse, a large building, in a beautiful situation, about three miles from the town, surrounded by 300 acres of land, principally under cultivation, the labourers on which are all paupers. It seems very well conducted, presenting, in this respect, a favourable contrast to similar institutions in some of the other large towns: the house is clean, orderly and comfortable; and really, with plenty of good food and clothing, occupation, either on the farm, or at any trade which he may be acquainted with, care taken

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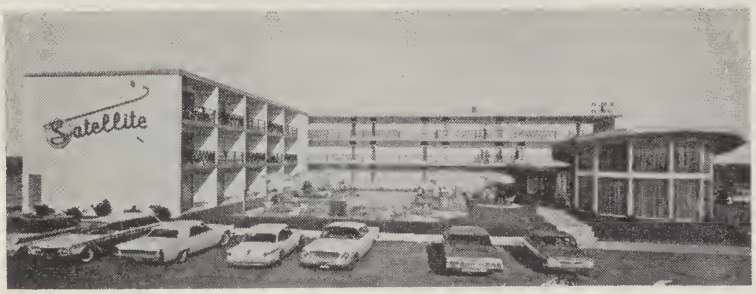
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of him when he is sick, and the power to go away when he pleases, the inmate must lead a very satisfactory life; indeed those to whom I spoke admitted it, and said distinctly that they were far better off in point of physical comforts than the generality of labourers in the neighbourhood at this moment (a period of distress, be it recollected), not to speak of the slaves. Now this must be wrong. Without any wish for harsh tests of destitution, it is surely not too much to say that the industrious labourer, who struggles to maintain himself and his family independently, ought not to see his next-door neighbour, equally able-bodied and capable in every respect, but who prefers the comparative idleness of an almshouse, better off than himself. The principle is false, and in a crowded state of society would be fatal. As it is, though applicants are never rejected, I was surprised to find that the average number of inmates does not quite amount to 600; but the easy access to the West, and the fact that a large proportion of the lowest class are slaves (who of course are not admitted), accounts for this: about two-thirds of the paupers are native Americans, the rest almost entirely Irish and Germans.

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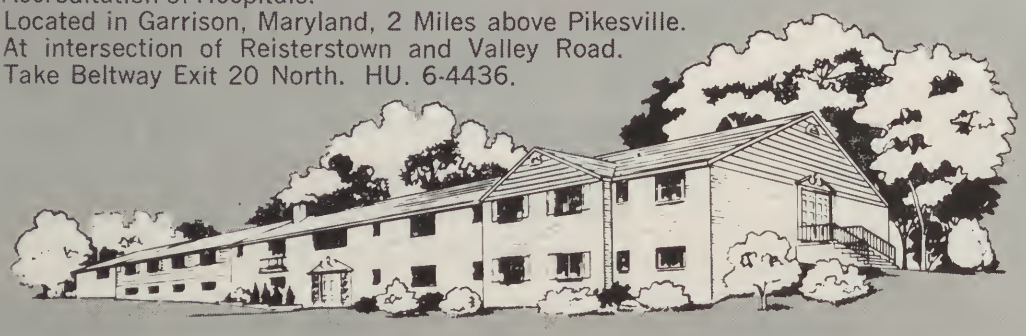
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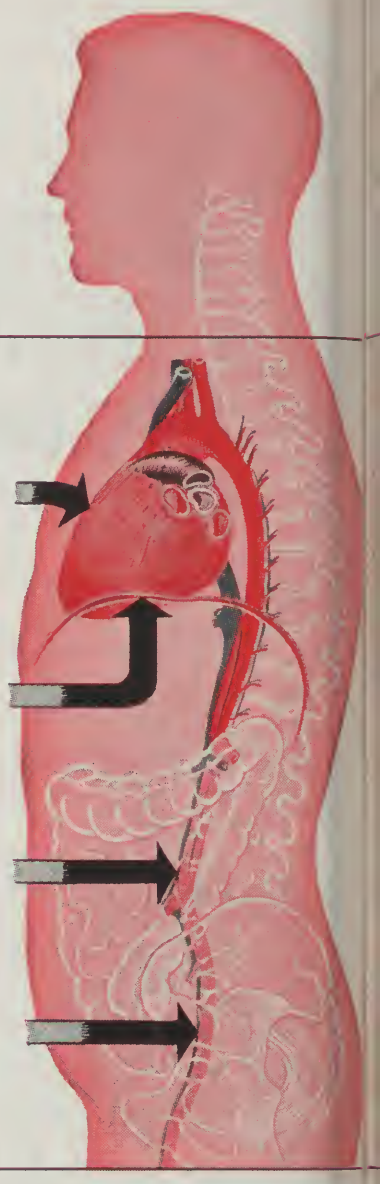
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The Harford County Medical Society, meeting at the Bayou Restaurant, Havre de Grace, on December 16, elected the following officers for 1966: **Alfred W. Grigoleit, MD**, president; **John A. Carriere, MD**, vice president; **W. H. Sadowsky, MD**, secretary; **Edward J. Simon, MD**, treasurer. Delegates to the Medical and Chirurgical Faculty are: **Philip W. Heuman, MD**, and **James McC. Finney, MD**, with **Willard P. Hudson, MD**, and **Charles J. Foley, Jr., MD**, as alternates.

Speaker of the evening was **John H. Janney, MD, MPH**, chief epidemiologist of the State Health Department, who described Health Department activities in the field of venereal disease. **Mr. James Mastrey**, USPHS field worker in Harford County, was also introduced.

James McC. Finney, MD

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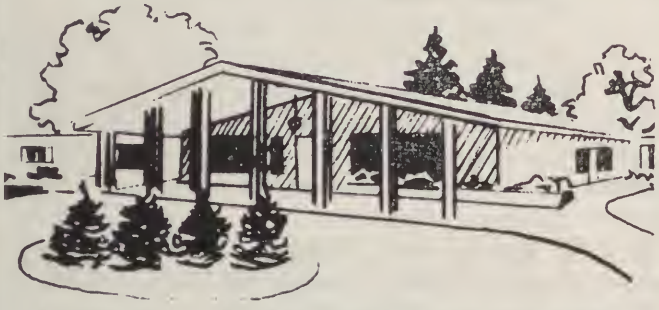


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WICOMICO COUNTY

At the February meeting, members of the Wicomico County Medical Society heard the State Commissioner of Health, **William J. Peeples, MD,** describe requirements for the home health services provided under the new Medicare law.

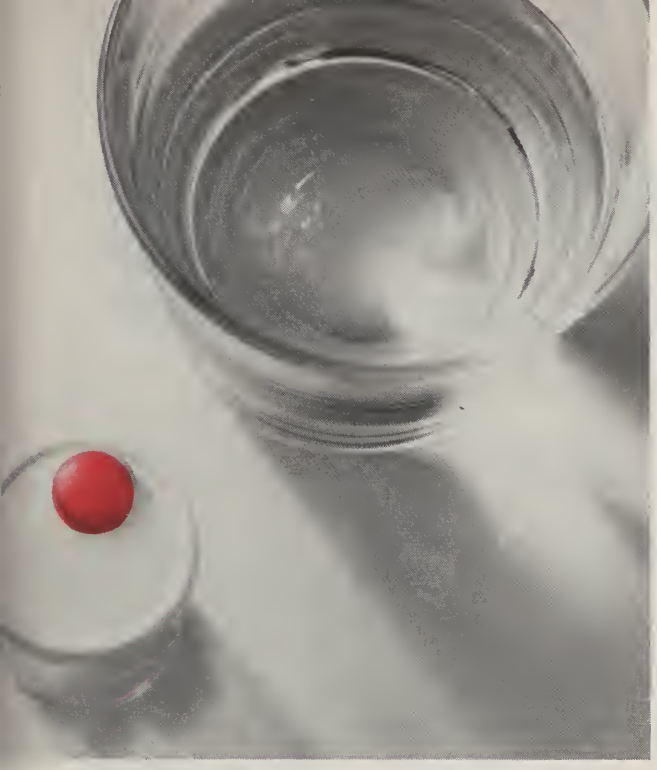
Dr. Peeples outlined the organizational structure which would be required to provide these services, the anticipated cost, and sources of possible financing to cover the deficit expected from federal payments.

After the presentation and a question and answer period, the medical society voted to ask the nominating agency to consider appointment of three medical society members to the health services advisory board, and endorsed health department administration of the program.

Among other actions taken at the same meeting, a motion was passed in support of the "implied consent" bill introduced by Senator Mary L. Nock at the current session of the Maryland Legislature. This bill provides for chemical testing of drivers suspected of being under the influence of alcohol.

Other special guests at the February meeting included **Edward Davens, MD,** deputy health commissioner, **DeWitt Boyd, MD,** health department liaison officer, **Mrs. Margraff,** also of the State Department of Health, **Ivory U. Sully, MD,** president of the Worcester County Medical Society, and **C. G. Rawley, MD,** president of the Somerset County Medical Society.

Mrs. Kit Hargreaves





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Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

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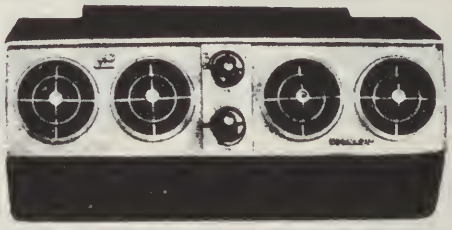
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Medicine—The Outward Look From Within A Specialty

CHARLES S. PETTY, MD
Past President, Maryland Society of Pathologists, Inc.

Societies and other groups of individuals with common interests often find themselves existing for their own purposes. This tendency, tempting though it may be, must be resisted if that particular body of men is to create a durable and useful tool for mankind. Specialty groups in medicine have been accused, often with some element of truth, of existing only for their own aggrandizement.

The Maryland Society of Pathologists, Inc., is one such specialty group which has been so charged. As the outgoing president of this organization, I feel a duty to make note of the outward-directed activities of the organization during 1965. It is with a comfortable feeling that I can detail several activities completely devoted to the broad aspects of medicine and not to the narrow realm of pathology.

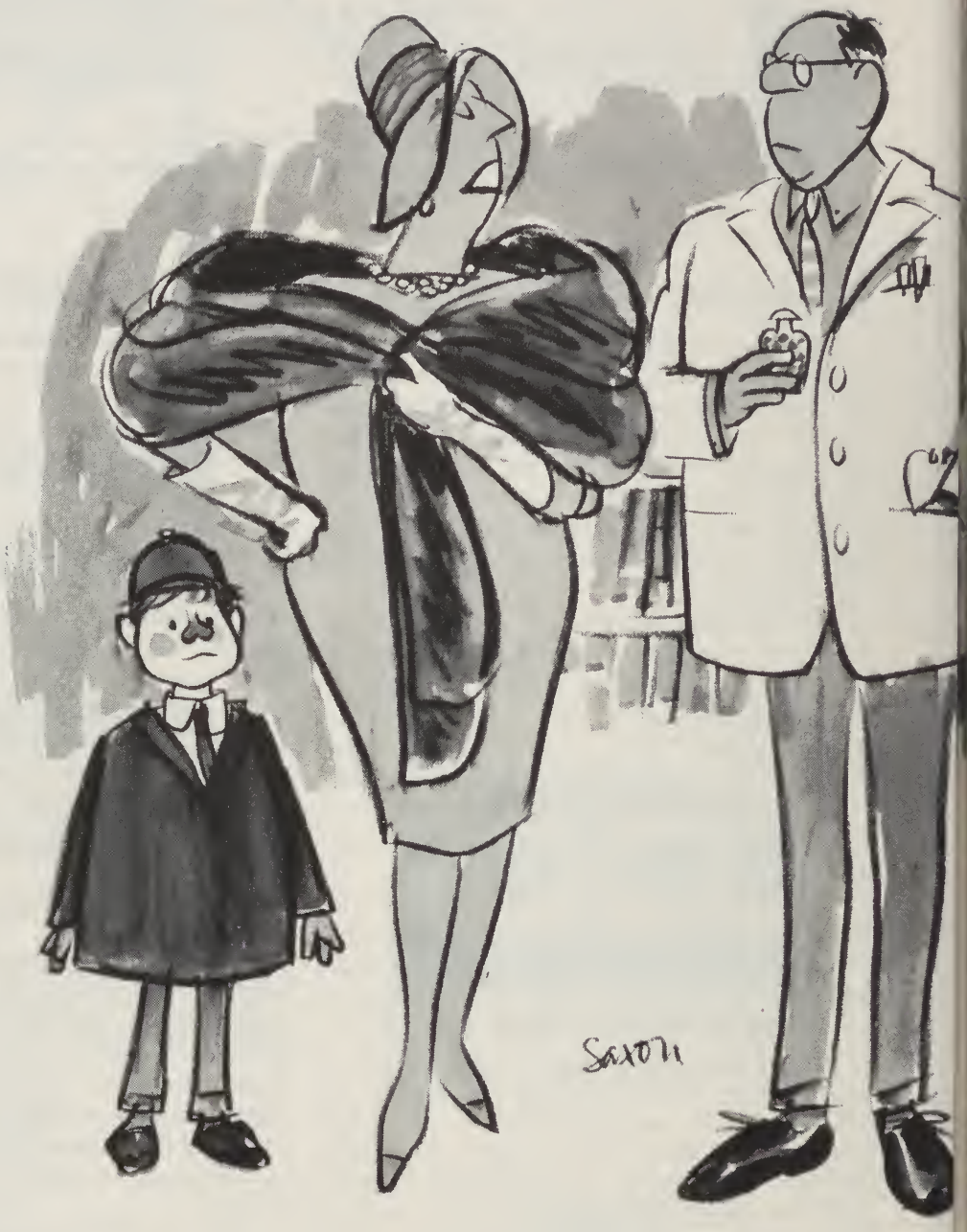
1. The Medical and Chirurgical Faculty of Maryland, pleased with the health evaluation tests for physicians at the annual meeting, again requested the Maryland Society of Pathologists, Inc., to chair and to implement this program. In 1965, a dozen or more pathologists, all members of this Society, directed the analysis of blood and urine specimens and the statistical evaluation of results derived from the nearly 250 physicians who took the opportunity to check their own health status. The Maryland Society of Medical Technologists, the Heart Association of Maryland, the Maryland Ophthalmological Society, and the Maryland Radiological Society shared in offering this screening program to physicians. This project was brought to completion by a specialty group working toward the goal of better medicine in its broadest sense.

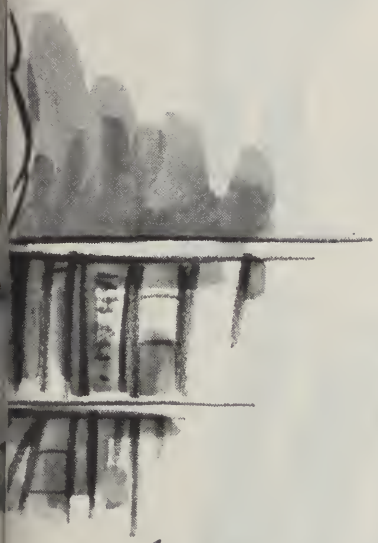
2. The Maryland Society of Pathologists, Inc., has contributed members active in the proper interpretation and, hopefully, the proper instrumentation of the controversial Medicare legislation. This activity of the Society is directed toward the progress of American medicine in its broadest aspects, not simply to the furtherance of a specialty group.

3. The educational program, begun years ago as a joint activity wtih the Maryland Society of Medical Technologists, was continued during 1965. Under the auspices of this program, workshops, seminars, discussions, and other forms of education have been carried out. During the past year, seminars in renal function, hematology, and clinical enzymology were held and were well attended, primarily by the medical technologists from the state.

4. A page is published monthly in the MARYLAND STATE MEDICAL JOURNAL by the Maryland Society of Pathologists, Inc. This provides information of interest and value to all physicians. During 1965, topics such as "Preservation of Medical Evidence," "The Medical Case in the Court of Law," "Exfoliative Cytopathology," "Administration of Blood and Other Intravenous Fluids in the Baltimore Area," were presented for the benefit of physicians in fields other than pathology.

These efforts do not comprise the entire outward look from within the specialty nor the entire outward directed program from within the Maryland Society of Pathologists, Inc. However, these four activities, emphasizing better health for physicians, education for physicians and technicians, and the broad aspect of the social impact of Medicare, are part of a small specialty's contribution to the betterment of medicine as a whole.





Look, Doctor, what he needs is a shot of penicillin.

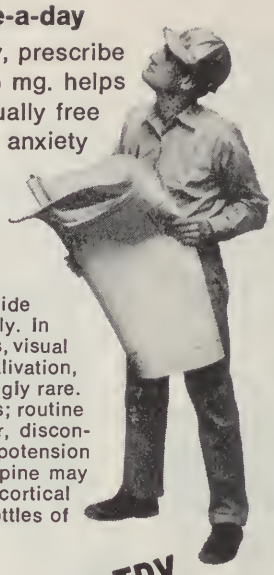
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Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.
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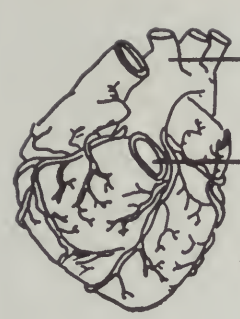
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The Heart Page

Joseph C. Fitzgerald, MD—*Editor*

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Evaluation of the Hypertensive Patient

JAMES L. CLIFFORD, MD

Successful treatment of the hypertensive patient depends on an accurate diagnosis. The evaluation has three major objectives: 1) to establish the consistency of the blood pressure elevation, 2) to determine the extent of target organ involvement, 3) to determine if there is an underlying specific cause for the hypertension. The last objective is extremely important since it may be surgically correctable.

The history should establish the time of onset and the familial prevalence, since these factors may vary between essential and secondary hypertension. Symptoms directly attributable to blood pressure elevation are not common early. Their presence may indicate significant underlying target organ involvement. A history of diabetes, motor lability, muscle weakness, and physical stress should be noted.

Physical examination should include evaluation of the optic fundi and a neurologic examination. Blood pressure determinations should be done repeatedly to determine the basal level. If the patient is hospitalized, the basal pressure may be obtained by sodium amytal sedation. Auscultation of the blood pressure in the lower extremities may be used to rule out aortic coarctation. Hypertension is assumed to be associated with accelerated atherosclerosis, and the manifestations should be considered. The pulsations in the extremities, carotid arteries, and the abdominal aorta should be palpated. Abdominal aortic aneurysms are more common with blood pressure elevation. Auscultation of the carotid and femoral arteries, the abdomen, and the flank may reveal a significant bruit.

The purpose of the basic laboratory investigation is to indicate what further diagnostic procedures are needed and to assess the degree of involvement of the organs tested. In addition to the CBC and urinalysis, a BUN, PSP, urine colony count, and serum sodium, potassium, chloride, and CO_2 should be obtained. An ECG may show evidence of cardiac enlargement. X-ray studies should include a postero-anterior and lateral chest film and a timed IVP with films taken at one, three, and five minutes. In unilateral renal disease the dye may appear earlier in the unaffected side. A discrepancy of 1cm or more in length of the kidneys suggests that the smaller kidney may be involved.

The following specific causes of blood pressure elevation should be further studied, if suspected:

1. **Bilateral renal disease.** Indications are anemia, azotemia, proteinuria, abnormal urinary sediment, or a history of previous renal disease. Useful studies are quantitative protein determinations, retrograde urogram, urinary sediment examination, and renal biopsy.
2. **Unilateral renal disease.** There may be sudden or early onset of hypertension or acceleration of a pre-existing hypertension. History may indicate abdominal pain, trauma, or evidence of thrombotic or embolic phe-

Dr. Clifford is a former chief of the Hypertension Section of the Heart Disease Control Program of the United States Public Health Service.



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nomenon. Auscultation may reveal a bruit over the abdomen or flank. The IVP should be noted for discrepancy in renal filling time or size. Renal arteriograms, the radioisotope renogram, and split renal function studies allow complete evaluation.

3. **Pheochromocytoma.** The blood pressure elevation may be sustained or paroxysmal. If the diastolic pressure is above 110 mm Hg, a regitine test may be used. A diastolic pressure below this calls for histamine stimulation. Specific information is obtained from the collection of a 24-hour urine specimen for catecholamines.
4. **Cushing's syndrome.** Physical findings are moon face, obesity, hirsutism, and abdominal striae. There may be leukocytosis, polycythemia, diabetes mellitus, and kidney displacement by x-ray. The specific diagnosis is obtained by 24-hour urine collection for 17-keto and 17-hydroxycorticosteroids and their reaction to dexamethasone suppression.
5. **Primary aldosteronism.** Clinical manifestations are periodic muscle weakness or paralysis, paresthesias, polyuria, and nocturia. Laboratory studies may indicate serum potassium depression with elevation of the CO_2 and sodium. Current studies indicate that the condition is present long before electrolyte changes occur. A 24-hour urine collection for aldosterone should be obtained. Secondary aldosteronism frequently is associated with accelerated hypertension or hypertension of renal vascular origin.
6. **Coarctation of the aorta.** The blood pressure is lower in the legs than in the arms in this condition. Rib notching or a small aortic knob may be seen on x-ray film. Angiography will definitely establish this diagnosis.

REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

THE BURDEN OF CHRONIC DISEASE

Survey of 556 Serial Admissions to the Acute Medical Service at the Baltimore City Hospitals

DOUGLAS CARROLL, MD

The medical care of patients with chronic diseases is a major public health problem. This survey attempts to identify the diseases which cause the most prolonged disability, use up the most hospital time, how much they are benefited by hospitalization, and what their disposition may be.

Between November 1, 1961, and March 1, 1962, 556 patients were admitted to the acute medical wards at the Baltimore City Hospitals. Sixty per cent were white, and 58% were male. Three per cent were under 20 years (15 is the lowest age on the medical wards); 8% were in the third decade, 10% in the fourth, 11% in the fifth, 17% in the sixth, 21% in the seventh, 19% in the eighth, 10% in the ninth, and 1% was over 90. Half of the patients were over 60.

Many patients had more than one disease, and it was often difficult to specify the principle disease. It was usually possible, however, to identify the disease causing immediate admission to the hospital; this was called "major disabling diagnosis."

Diagnosis and Age

Table 1 shows the major disabling diagnosis in relation to age, sex, and race. Arteriosclerotic and hypertensive cardiovascular diseases were the most common causes of admission. Pulmonary tuberculosis, pneumonia, and emphysema were the leading pulmonary diseases (excluding neoplasms of the lung). The most common psychiatric diseases were acute and chronic alcoholism, suicidal attempts, and chronic brain syndrome. Bronchogenic carcinoma was at least three times more frequent than any other neoplasm. Of the gastrointestinal diseases, liver disease, upper gastrointestinal hemorrhage, and acute gastroenteritis were the most common diagnoses (many being complications of alcoholism). Diabetes mellitus was five times as common as all other endocrine and metabolic diseases combined.

Duration of Major Disability

Table 2 shows the impact of the major disabling diagnosis in terms of duration of disability and length of hospital stay. The time of onset of disability was that point at which the patient no longer contributed to the community in terms of work, self-support, or self-care appropriate to his age, sex, and disability and began to depend

Table 1
Major Disabling Diagnosis Causing Admission

	Total	White	Non-White	Male	Female	Under 20	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Respiratory	92	48	44	68	24	1	8	9	16	20	17	12	7	2
Cardiovascular	118	79	39	65	53	0	2	4	13	22	29	30	18	0
Cerebrovascular	45	34	11	19	26	0	1	1	2	3	14	18	5	1
Psychiatric(CBS)*	69	44	25	35	34	2	11	14	4	11	11	8	8	0
Neurologic	22	16	6	16	6	1	2	3	5	5	4	2	0	0
Musculoskeletal	15	7	8	7	8	1	1	0	2	3	1	6	1	0
Neoplasms	67	33	34	40	27	1	1	6	9	11	20	14	4	1
Endocrine	27	17	10	9	18	2	4	3	4	4	6	4	0	0
Hemic & Lymph	13	7	6	7	6	4	2	1	0	0	1	2	3	0
Gastrointestinal	51	28	23	30	21	4	7	8	7	14	7	1	3	0
Urogenital	27	13	14	18	9	1	5	3	2	3	2	6	4	1
Dermatologic	5	4	1	4	1	0	0	1	0	0	3	0	1	0
Other	5	5	0	2	3	0	0	0	0	1	3	0	1	0
Total	556	335	221	320	236	17	44	53	64	97	118	103	55	5

*This category includes acute alcoholism with delirium, suicide, and chronic brain syndrome (CBS)

Table 2
Duration of Disability Prior to Hospital Admission and Duration of Hospital Stay

	Duration of Disability						Time in Hospital			
	1 wk	1 mo	6 mo	1 yr	More than 1 yr Less than 5 yr	5 yr+	1 wk or less	1 wk to 1 mo	1 mo to 6 mo	6 mo or more
Respiratory	30	21	13	10	13	5	24	42	13	13
Cardiovascular	30	12	17	27	27	5	33	65	17	3
Cerebrovascular	12	8	7	5	11	2	16	15	12	2
Psychiatric	16	5	11	12	19	6	25	29	13	2
Neurologic	6	4	0	6	5	1	8	9	3	2
Musculoskeletal	4	2	1	0	6	2	2	6	5	2
Neoplasms	3	3	24	20	11	2	15	35	16	1
Endocrine	3	8	5	6	4	1	4	15	8	0
Hemic & Lymph	5	2	1	1	1	3	3	10	0	0
Gastrointestinal	19	6	10	5	7	4	17	24	9	1
Urogenital	7	6	10	0	3	1	6	15	6	0
Dermatologic	1	0	2	0	1	1	0	2	3	0
Other	3	2	0	0	0	0	2	3	0	0
Total	139	79	105	92	108	33	155	270	105	26

Table 3
Disposition of Patients and Status at Discharge

	Disposition from Medical Service					Status at Discharge from Medical Service		
	Home	Nursing Home	D Bldg.	Death	Disch. or Transfer to other Hospital	Improved	Unchanged	Worse
Respiratory	54	1	6	18	13	64	10	8
Cardiovascular	67	1	10	39	1	75	5	23
Cerebrovascular	11	2	13	19	0	19	7	8
Psychiatric	39	0	16	8	6	44	17	5
Neurologic	16	0	2	2	2	14	6	0
Musculoskeletal	5	0	8	0	2	7	6	2
Neoplasms	28	1	1	37	0	12	17	27
Endocrine	22	0	4	1	0	25	1	0
Hemic & Lymph	9	0	3	1	0	10	2	1
Gastrointestinal	39	0	4	7	1	39	5	7
Urogenital	11	0	2	14	0	11	2	11
Dermatologic	1	0	4	0	0	4	1	0
Other	4	0	0	1	0	4	0	1
Total	306	5	73	147	25	328	79	88

on social agencies, hospital, or family *because of his disease.* Since this determination was not always accurate, many of the figures for duration of disability are approximate.

Forty-two per cent of the patients had been disabled for more than a year before admission, 25% for one week, and the remaining 33% from one week to one year.

The following percentages of the diagnostic groups had been disabled for more than a year: neurologic, 55%; psychiatric, 54%; musculoskeletal, 53%; neoplasms, 50%; cardiovascular, 50%; cerebrovascular, 41%; hemic and lymph, 38%; respiratory, 31%.

Diagnosis in Relation to Time in Hospital

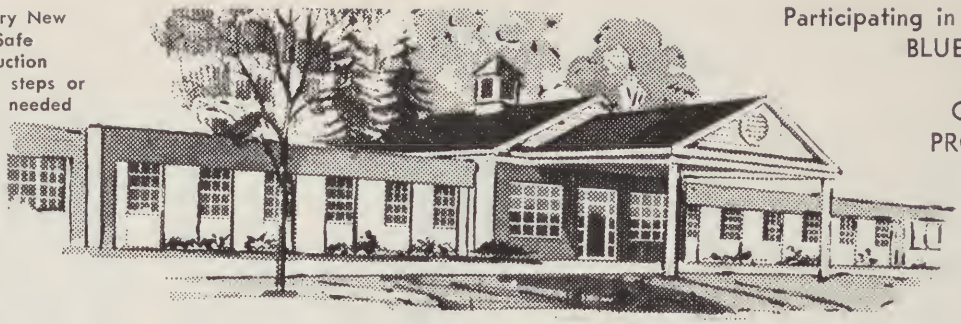
Table 3 shows that a high death rate within six months after hospitalization partially accounts for the small number of patients with cardiovascular disease and neoplasm still in the hospital at the end of six months. The high mortality in patients with cerebrovascular disease is explained by the multiple diseases (hypertension, arteriosclerotic heart disease, diabetes mellitus, and renal failure) so frequently associated.

A large number of patients with respiratory, cardiovascular or cerebrovascular, psychiatric, and musculoskeletal disorders were transferred to a subacute hospital to await final transfer to a nursing home (Table 3). These represent the long term patients generally cared for by nursing homes.

Summary

This survey demonstrates the toll of chronic disease in terms of the prolonged dependence before hospitalization, the long hospital stay with little improvement (particularly in patients with

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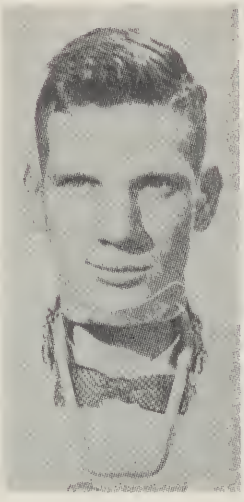
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BALTIMORE, MD.

cardiovascular disease, uremia, respiratory failure, and neoplasms), and the overwhelming morbidity caused by alcoholism, diabetes mellitus, and arteriosclerosis (and their complications).

Most patients admitted to the Baltimore City Hospitals are elderly welfare patients and therefore are a selected group with a high incidence of disabling chronic diseases. Probably the advent of Medicare will shift some of this population to other hospitals now treating mostly private patients.

In dealing with these patients, there are five primary requirements for good medical care: 1) no curable or treatable disease should be missed in the diagnosis; 2) a comprehensive survey of the patient's potential for self-help and independence must be made; 3) every effort must be made to establish each patient at his maximal medical, psychological, physical, domiciliary, financial, familial, and vocational potential; 4) when all resources for the patient's benefit have been fully exploited, the patient must be placed promptly in a facility most appropriate for his needs; 5) he must be followed with adequate medical and social care.

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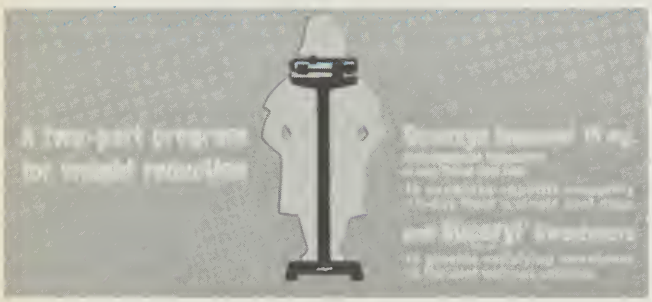
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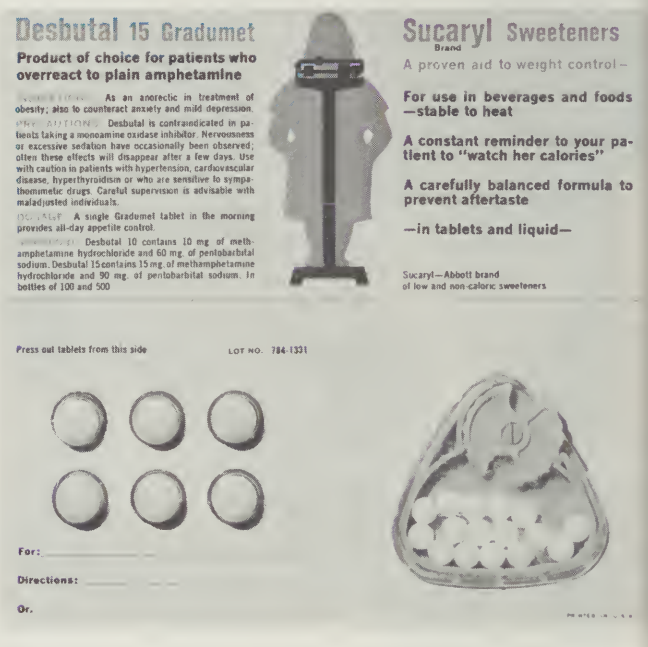


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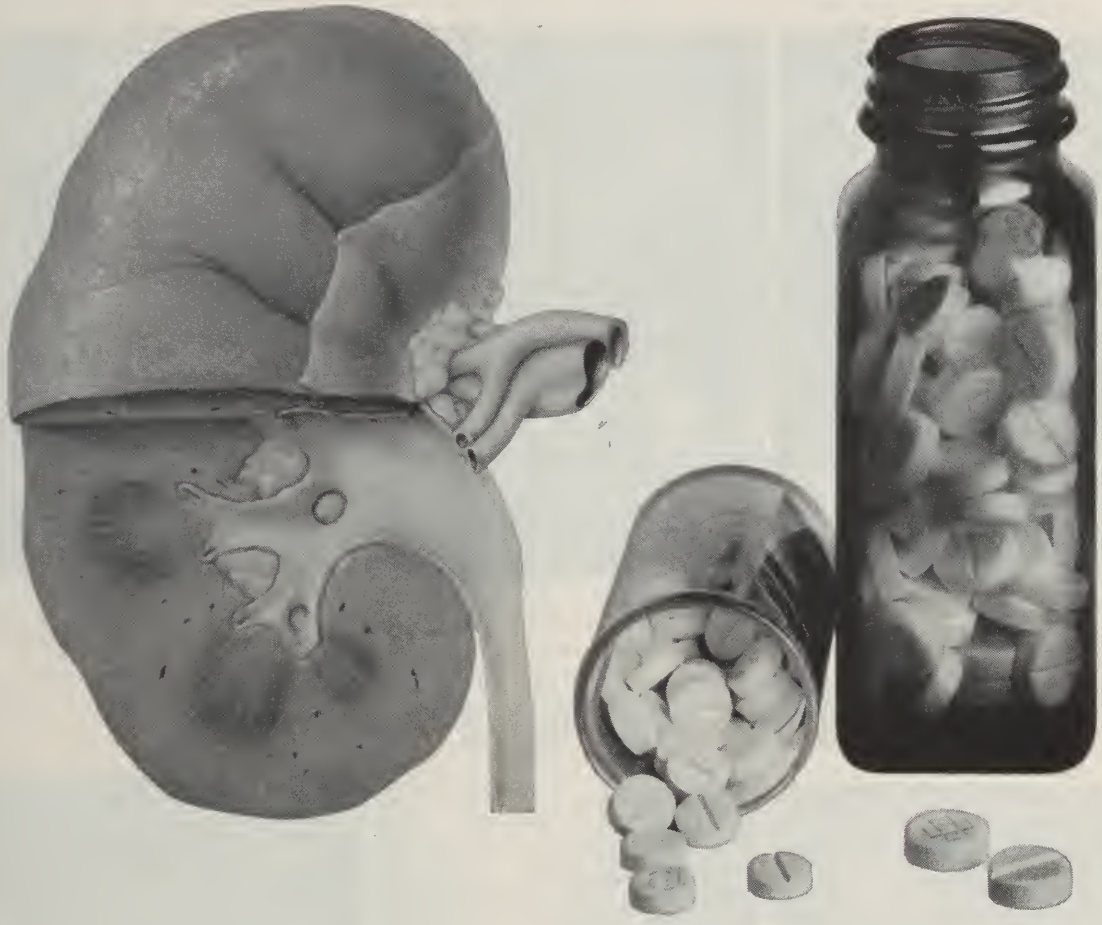
PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

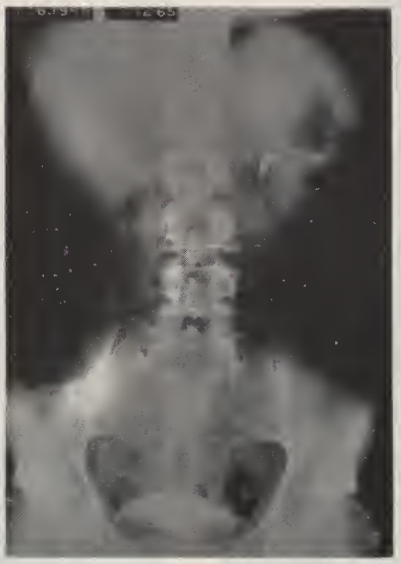
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1A. 44 WM. Admitted to hospital for evaluation of right lower quadrant mass. Non-visualization of right kidney.



1B. Right kidney is not visualized, but terminal ureter on right is seen and its proximal portion is displaced medially.



1C. Right posterior oblique view projects calyceal system away from bony pelvis allowing visualization of a right pelvic kidney.

RADIOGRAPHIC DIAGNOSIS OF PELVIC KIDNEY

HUGH F. MORRISH, MD

Absence of a functioning kidney in the normal position, as shown by intravenous pyelogram, should suggest the possibility of an ectopic kidney. Ectopic kidneys usually are located in the pelvis and may be extremely difficult to visualize by routine intravenous pyelography. Oblique views frequently project the calyceal structures of the pelvic kidney away from the bony structures of the pelvis, enabling correct interpretation.

Ectopic pelvic kidney is found in one in 700-800 autopsies.[1] Its cause is failure of the kidney to ascend to its normal position during fetal life, being held in abnormal position by vascular attachments which are characteristically aberrant.

From the Department of Radiology, The Johns Hopkins Hospital, Baltimore. This work was supported in part by USPHS Grant No. 5TI GM 1328.



2A. 24 WM Abdominal mass detected on routine employment physical examination. Non-visualization of the right kidney.

The ectopic kidney derives its blood supply from adjacent major vessels, usually the iliac or hypogastric arteries. Frequently smaller and more lobulated than normal, it is commonly associated with malrotation and anterior position of the renal pelvis. This configuration may have a bizarre appearance on the pyelogram. The length of the ureter corresponds to the position of the kidney and is short. The short ureter helps differentiate the congenital ectopic kidney from the ptotic kidney which has a normal ureter. Pelvic kidney is more common in males than in females and more often involves the left kidney.

The patient may present with a pelvic mass. Occasionally this mass may obstruct labor. Inflammatory disease within the ectopic kidney may simulate appendicitis or other intra-abdominal disease. Ectopic kidneys may exert pressure on the bladder or bowel.

The proper radiographic diagnosis requires a high degree of suspicion and keen observation. Failure to demonstrate a functioning kidney in the normal position demands a persistent search for a possible ectopic kidney. Fragmentary filling of the calyceal system may be almost impossible to identify when superimposed upon the bony pelvis. The use of oblique views frequently allows excellent visualization of the collecting system of the pelvic kidney by projecting it free of the bony pelvis (figs 1C and 2C). Visualization of the terminal ureter without recognition of the kidney itself indicates ectopic kidney (figs 1B and 2B).

Routine oblique views in intravenous pyelography are recommended not only because they provide the diagnosis of pelvic kidney but also because they are useful in evaluating ureteral stones, renal and nonrenal calcifications, and the calyceal systems themselves. Often oblique views give excellent visualization of the renal contour.

The relative frequency of pelvic kidney calls for caution in the routine use of pelvic pressure as a means of obtaining better filling of the upper urinary tracts during excretory urography. Pressure should not be applied until the kidneys have been located, either by an adequate preliminary examination or, preferably, after the first excretory radiograph.

Summary

The most important feature in the radiographic diagnosis of pelvic kidney is a high index of suspicion followed by a careful search for the ectopic kidney. This search is motivated by failure to visualize the kidney in the normal position or by visualization of the distal ureter without appreciation of the kidney itself.

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2. Emmett, J. L.: *Clinical Urology,* W. B. Saunders Co., Philadelphia, 1964.



2B. Right terminal ureter visualized but calyceal structures not well seen overlying the sacrum.



2C. Oblique view demonstrating a right pelvic kidney.



2D. Right retrograde pyelogram confirming presence of right pelvic kidney.

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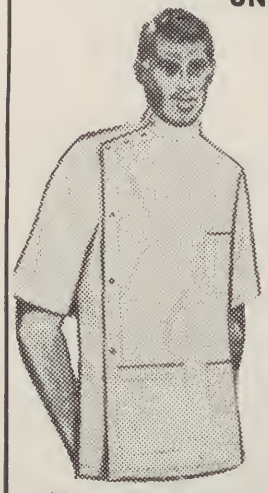
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Broad Attack on Alcoholism Urged

PHILADELPHIA—A comprehensive public health approach to alcoholism, instead of current "piecemeal" methods of research and treatment, was urged here at the 19th Clinical Convention of the American Medical Association.

Calling on the states to build "strong, efficient local health departments" to cope with alcoholism, Dr. Ralph E. Dwork, Pennsylvania Deputy Secretary of Health, declared that the field is currently "dominated by the clinician and the "alcohologist," although, "like geriatrics, alcoholism requires the concerted effort of medicine, public health, mental hygiene, welfare, housing authorities, education, etc., if any effective progress is to come."

Dr. Dwork told a session on alcoholism that current studies have failed to produce reliable morbidity and mortality rates, an acceptable concept of etiology, or even a clear profile of the alcoholic.

The health official said that the answer must be sought not only in studies of the individual alcoholic, but in the nature of the community that he comes from. Neither the number of patients nor the economic losses caused by alcoholism, he said are "the only aspects that make this a public health problem. Its interrelationships with highway accidents, delinquency and crime, use of narcotics, disruption of the family, and elevated suicide rates are other social manifestations," he added.

In arguing for the public health agency as the logical focus for handling the problem, Dr. Dwork asserted that only a multi-disciplined approach, based on a concept of multiple causation and able to use a variety of public health techniques, could cope with a problem as complex as alcoholism. What is needed, at the very outset, he said, is to develop a "workable epidemiology of alcoholism."

"Reliable and valid mortality and morbidity rates are virtually nonexistent," Dr. Dwork charged. "We have had to rely on various parameters of estimation, such as the sale of alcoholic beverages or deaths with underlying cirrhosis. While these have served and are still serving a useful purpose, it is essential for us to develop a greater degree of sophistication."

Similarly, he said, research has developed on a piecemeal basis. "We have bits and pieces of information on alcohol use in Italians, Jews, Chinese, and in the Irish. We have studied the phenomenon in high schools and colleges, in industry and elsewhere. We have, in our efforts to delineate the profile of the alcoholic, subjected both alcoholics and nonalcoholic controls to a barrage of psychologic tests. No clear discernible pattern has emerged—at least, one we can test for.

No Definitive Explanation

"Analytical psychiatric probing," he went on, "has offered various explanations such as latent homosexuality, oral fixation, and self-destruction. None of these has been sufficiently definitive to be really helpful . . . At any rate, there is growing unhappiness with our research efforts in the field of alcoholism. There is growing impatience at its piecemeal approach."

Reprinted from *Medical Tribune,* December 27, 1965.

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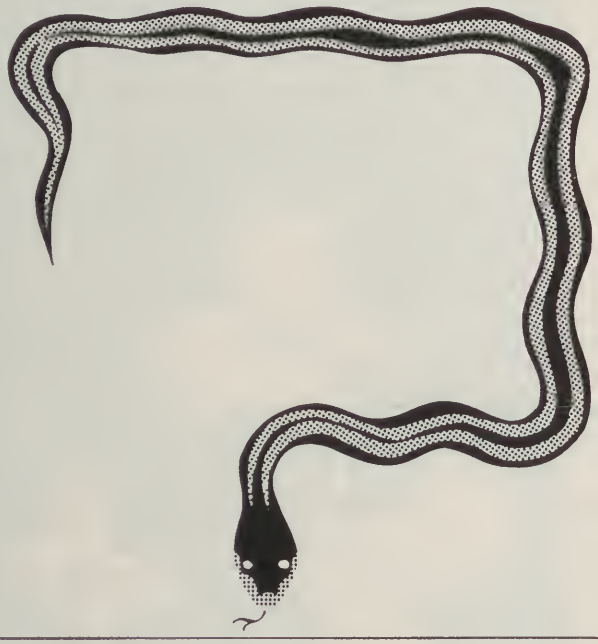
Dr. Dwork pointed out that the public health agency could launch newer statistical sampling techniques, examine the longitudinal and long-term aspects of alcoholism, and utilize teams who would be "working together, not just at some laboratory bench, but in the community and natural environment in which our patient is found and exists. Indeed, it may well be that here, too, our patient will be the 'community itself'—not just the alcoholic as an individual."

While arguing for the public health agency, Dr. Dwork asserted that far too many such agencies are still living in "the horse-and-buggy age." "More than one health department in this country is directed by a nonphysician," he declared. "More than one is headed up by a physician who has had no training in public health. Too many of these are refugees from unsuccessful practices or those who are seeking refuge and comfort after a cardiac accident."

In making these points, he called on the profession and on individual physicians to help strengthen the public health agency within the community.

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 11—Postpartum Hemorrhage

The patient was 37 years old, para 6. She was admitted to the labor floor at 3 PM, August 10, after an uneventful and normal antepartum course. She reported spontaneous rupture of the membranes 15 minutes before admission. Admission physical examination revealed moderate bloody show, the cervix 2 cm dilated and 50% effaced, vertex presenting. Contractions were occurring every three minutes, blood pressure was 130/90, pulse rate was 80 per minute and regular, and temperature was normal.

She was complaining bitterly of severe back pain and 30 minutes after admission received 1½gr seconal by mouth, and 5mgm Trilafon intramuscularly. She continued to complain of abdominal and back discomfort and became all but unmanageable. At 5 PM she was given 100mgm Demerol and .4mgm Scopolamine. The cervix was 4cm dilated.

At 5:30 dilatation was 8cm, and the patient was taken to the delivery room. Saddle block anesthesia with Xylocaine was administered at 5:50 PM. At this time the fetal heart rate was noted to have slowed to 80 per minute and was somewhat irregular, and oxygen was administered by mask. At 6 PM, after performance of central episiotomy, she was delivered by low forceps of a full-term living boy.

The placenta was expressed easily soon afterward. No lacerations were found in the uterus, cervix, and vagina. One ampoule of Syntocin was administered intravenously and one ampoule of Methergine intramuscularly. A vaginal pack was inserted. Routine repair of the episiotomy was completed at 6:20 PM. Some bleeding through the vaginal pack was noted, and an additional ampoule of Syntocin was given intramuscularly.

Upon completion of the episiotomy repair, the vaginal pack was removed and excessive, heavy, bright red bleeding was noted. Intravenous 5% dextrose in 0.2% saline had already been begun, and two ampoules of Pitocin were added to the intravenous fluids.

At 6:40 PM, blood was drawn and sent to the laboratory for typing and cross-matching. The report indicated the hemoglobin to be 12.2gm and hematocrit 37%. At this time the blood pressure was 115/80, pulse rate 96, and the patient continued to bleed. At 7:15 the blood pressure had fallen to 80/60 and the patient became unmanageable, making it difficult to maintain the administration of intravenous fluids. The first unit of blood was received from the blood bank at 8:10 PM but could not be started until 8:30 because of the patient's unmanageable behavior. Ultimately a cut-down was accomplished, and one unit of whole blood was administered by pump. The patient, however, was pronounced dead at 8:45 PM.

Permission for autopsy was obtained. No lacerations or perforations of the uterus or birth canal were found, nor was there any retained placental tissue. The cause of death is listed as postpartum hemorrhage due to uterine atony.

Comment

The committee voted that this death was preventable on the basis of delay in the administration of blood. The total elapsed time

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between delivery and death was two hours and 45 minutes. An essential part of any modern obstetric service is that of providing prompt and massive blood replacement in cases of unusual blood loss. Had one or two units of Group O, Rh negative blood been immediately available and administered promptly while routine cross-matching was being performed, the committee members believed that the outcome of this case would have been different.

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Pediatrics

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WILLIAM STIFLER, JR., M.D., Chairman

RAY HEPNER, M.D., Editor

PHYSICAL ACTIVITIES FOR SCHOOL CHILDREN WITH HEART DISEASE

MILTON MARKOWITZ, MD
CATHERINE A. NEILL, MD

Physicians are often asked to advise parents on the amount and kind of physical activity for children with heart disease. When a cardiac child is symptomatic, the answer is easy: the patient is told to avoid, insofar as is possible, those exertions which cause symptoms. But most children with heart disease are asymptomatic, and the physician finds it difficult to determine the amount of permissible physical activity.

Often when the physician is uncertain or when he is confronted by anxious parents, he excludes the child entirely from physical education, regardless of the nature of the cardiac lesion. School nurses and physical educators are also wary of allowing patients with any kind of heart disease to exercise. Often the school medical report is not explicit, and restrictions which may have been intended for a limited period only are carried on for many years. Consequently, many asymptomatic patients are needlessly restricted in their school and extracurricular activities.

Many other children with loud functional or questionably organic murmurs are often restricted from a full program of normal activities. Some of these children become increasingly concerned over their health and become cardiac-conscious, neurotic adults. Others, recognizing that they can do more than their medical advisors appreciate, are frustrated by sitting on the sidelines. They exercise with even greater vigor outside of school and give considerable concern to their parents.

Most pediatric cardiologists agree that most children with heart disease are able to participate in physical education with few restrictions. This report discusses the indications for limiting physical exercise for childhood cardiac conditions.

From the Harriet Lane Home Cardiac Clinic, the Children's Medical and Surgical Center, Johns Hopkins Hospital, and the Departments of Pediatrics, Sinai Hospital of Baltimore and the Johns Hopkins School of Medicine.

Rheumatic Fever and Rheumatic Heart Disease

In the past, children were arbitrarily restricted from strenuous physical activity for at least one year after an attack of rheumatic fever, regardless of its severity. This practice may have been wise when severe attacks of rheumatic carditis were the rule rather than the exception; but there has been a sharp decline in the severity of rheumatic fever, especially in the number of damaging recurrent attacks, making the above dictum obsolete. The physician's recommendations should be based on the severity of the attack and the extent of residual heart disease.

No Valvular Disease.—Approximately 40% of patients with rheumatic fever today have either polyarthritis or chorea as their only major manifestation. The illness usually runs its course within three months. If at the end of this period there is no evidence of cardiac involvement, there is no need for any physical restriction. The

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SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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physician must emphasize to the parents that the child has no heart disease, yet he must stress the need to prevent recurrences. He must emphasize in his medical report to the school that the child is free of heart disease and that no restrictions in physical exercise are justified. School physicians and nurses sometimes still indiscriminately restrict all patients with a history of rheumatic fever.

Valvular Disease Without Enlargement.—Patients who are left with valvular damage with no or minimal cardiac enlargement are almost invariably asymptomatic and in general have an excellent prognosis. Nevertheless, the physician often needlessly restricts them from all competitive sports and other strenuous activities. The most common valvular lesion is mitral regurgitation. In approximately 25% of these patients, who remain free of recurrent attacks of rheumatic fever, the murmur disappears within five years. The murmurs of aortic regurgitation are more likely to persist; however, there is no evidence that restriction of physical activity improves the prognosis in patients with either mitral or aortic regurgitation. As long as these children are under medical supervision and follow the prophylactic regimen, restriction of physical activity is not necessary. During the first year after an attack, they should be examined at three-month intervals to make sure that cardiomegaly has not developed.

Valvular Disease With Enlargement.—Patients with a severe single episode of rheumatic fever or after recurrent attacks often have residual valvular disease with some degree of persistent cardiac enlargement. When the myocarditis has subsided and the cardiac findings have stabilized, most of these children tolerate ordinary physical activity quite well. They should be encouraged to participate in regular physical education classes, avoiding those activities that are known to produce symptoms. Strenuous competitive sports should be excluded, especially for adolescent boys, who are particularly prone to continue team activities despite discomfort rather than admit their disability.

Congenital Heart Disease

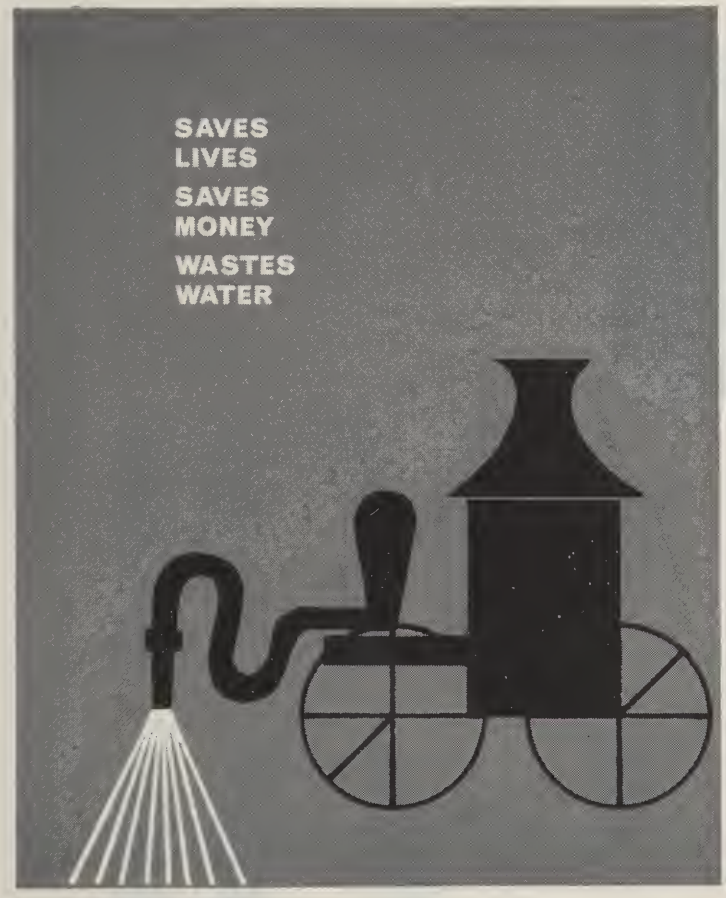
From the practical point of view, congenital cardiac lesions can be divided into (I) a hemodynamically minor group not requiring surgery, (II) a moderate group which may at some time require surgery, (III) a severe but potentially operable group, and (IV) an inoperable group. This type of classification is more important to the patient than the specific anatomic diagnosis.

Group I includes small left-to-right shunts, whether ventricular or atrial, mild degrees of aortic or pulmonic stenosis, coarctation of the aorta, and all lesions in which the x-ray and electrocardiogram is normal and the only evidence of heart disease is a murmur. ALL THIS GROUP SHOULD BE ALLOWED ABSOLUTELY NORMAL SCHOOL ACTIVITIES, including FULL participation in all the usual sports. We used to advise these children not to take part in competitive sports, but we now believe that such restrictions cause unnecessary confusion and distress. The only precaution is to advise the parents when the child is about 8 or 9, that he is unlikely ever to be eligible for a professional career in sports. Though only a small number of normal males ever actually embark on such a career, many boys may dream of it, and most parents can accept this philosophically.

Group II.—Many of these children with operable lesions have surgery about 5 or 6 years of age and, on entering school, are able to take part in all normal activities. The child who has had a patent ductus ligated or a ventricular or atrial defect satisfactorily repaired should be treated as a normal child. If he is awaiting repair of his defect or a decision regarding surgery has not been reached, we usually allow full activity if the child has little or no cardiac enlargement. If cardiac enlargement or symptoms are present, he should be excused from strenuous competition, racing, etc., but allowed to play games with his friends.

Group III includes all cyanotic patients with operable lesions and all severe cases of pulmonic or aortic stenosis. Usually, if restriction is indicated and the lesion is readily operable with low risk, it is better to undertake surgery and allow the child to return to full activity about six months postoperatively. In some cyanotic children it is safer to defer surgery.

These patients require careful individual consideration. Often the parents can discuss frankly with the school the fact that the child has a defect and request that he be allowed to take part in gym but be excused if he becomes unduly



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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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tired or cyanotic. Some sympathetic and cooperative teachers go to extraordinary extremes to include such a child as part of the group in physical education without overstressing him. Others will make no exceptions, and there is no alternative to withdrawing the child completely from all forms of physical education. A new teacher, a new school, or improvement in the child's condition may allow re-evaluation.

For this severe group, all racing in competition should be forbidden, and the child should not play on school teams. This is briefly expressed as *avoidance of competitive sports.* On the whole, the child should not be restricted any more than is clearly common sense for his particular lesion; for example, if he can only walk two blocks before being dyspneic, organized running activities are clearly impossible; but he may derive pleasure from swinging a baseball bat and letting a friend run for him. Dancing should never be forbidden, although the child will have to learn his own limitations.

Group IV.—This inoperable group includes patients with congenital heart disease causing great cardiac enlargement, severe complex cyanotic malformations, severe pulmonary hypertension, and obscure myocardiopathies. Most of these children should be restored to optimal physical condition, preferably in hospital, by use of digitalis and diuretics. A small minority, mostly those with additional noncardiac defects, should be in schools for the handicapped; but as a rule, we deplore these schools for such children and, whenever possible, allow them to remain in ordinary school, if necessary with elevator passes so they do not need to climb stairs. Although formal physical education is usually impossible for this group, they can be taught to do isometric exercises. They should also be encouraged to develop hobbies which do not involve a great deal of physical exertion.

SUMMARY

Children who recover completely from an attack of rheumatic fever or who have mild congenital or rheumatic heart disease should not be restricted in any school or outside activities.

Asymptomatic patients with cardiac disease associated with definite cardiomegaly should be restricted from strenuous or competitive sports but should be allowed to participate in all physical education activities which do not cause excessive fatigue.

Severely affected cardiac children should be encouraged to develop skills in appropriate hobby activities, preferably involving other noncardiac children with similar interests.

Physicians who care for children with heart disease but do not follow these patients into late adolescent and adult life often do not realize the emotional problems which can be created by unnecessary restrictions imposed on the child during his early years.



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Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

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Morris Scherr

Editor
Dick M. Hoover

FROM TB TO MR

Judith Schiff Pearl
Supervisor of Women's Activities,
Henryton State Hospital

For the first 39 years of its existence, Henryton State Hospital functioned as a TB treatment center under the jurisdiction of the Department of Health.

Three years ago, Henryton ceased operating as a TB hospital and began admitting "trainable" mentally retarded adults. On July 1, 1963, responsibility was transferred to the Department of Mental Hygiene. This necessitated an entirely new program at Henryton.

A day-care program for 28 retardates, all male, was begun in 1962. Criteria for their admission was: 1) continence, 2) ambulation, 3) ability to follow simple directions, 4) absence of severe behavior problems.

With its quota of 403 mentally retarded adults, the program's guiding principle is that full-time, planned activity and small-group therapy would enable residents to receive the individual training to develop latent abilities and to teach them socially acceptable behavior.

At the start we were able to place residents in groups of seven. Home economics, woodshop, arts and crafts, music, recreation, and work activity classes were scheduled for all groups. Emphasis was placed on self-reliance and neatness. Progress was rapid with individual supervision, and within a short time one-third of the residents were placed in foster care. Extended and short-term home visits were encouraged for the others.

Self-care and good personal habits are encouraged and developed by allowing the resident to perform such basic functions as self-cleanliness and the cultivation of good manners.

Pre-vocational training is offered to those who have demonstrated an aptitude. It stresses the development of manual dexterity and coordination necessary to perform a job, and it emphasizes good job habits. Actual job training is available through job placement within the hospital and on a day-placement basis in the community.

The program is planned to permit a normal, well-rounded development in as many different areas as possible.

Personal habits is an activity designed to emphasize various aspects of personal hygiene, good grooming, and good manners.

Motivation is an activity similar in concept to personal habits.

Games and reading stresses good leisure time habits.

In *woodshop* residents are taught proper care and use of tools.

Home economics teaches female residents the use and care of all domestic utensils, the planning and preparation of meals, and the repairing and sewing of clothing.

Arts and crafts stresses the use and care of a variety of tools and equipment, the development of handskills and coordination.

Outside activities are provided to allow for the expression of individual and group differences.

Religious activities are regularly scheduled. These services are conducted by clergymen of several faiths.

Adult education is scheduled for all residents who demonstrate reading ability. Such residents attend reading classes one hour per day.

From Maryland Steps Ahead, September, 1965 (a Department of Mental Hygiene publication).



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DEPARTMENT OF HEALTH

STATE OF MARYLAND

William J. Peeples, MD, MPH, *Commissioner*

Highlights

VIROLOGY LABORATORY REVIEWED

As part of a continuing effort to develop and maintain competent laboratory services, a survey of the activities of the Division of Virology was requested by the Department's Bureau of Laboratories. A specialist from the USPHS Communicable Disease Center (CDC) reviewed technical procedures, facilities, and educational and professional qualifications of personnel. The evaluation specimens previously distributed by the CDC were used to determine the level of competence of personnel. The CDC specialist was favorably impressed with the scope of activities in this field and with the competence and dedication of the personnel in the Virology Division.

NEW EARLY VIROLOGIC TEST FOR ENCEPHALITIS

Prompted by recent information from outbreaks of encephalitis in the United States in the past two years, the Bureau of Laboratories has replaced the complement fixation test to detect arbovirus encephalitis with a new serologic procedure to detect a different kind of antibody which appears in the patient's blood from the day of onset. It is now possible for the laboratory to provide an early alert of arbovirus activity in the state.

METROPOLITAN AREA AIR QUALITY SURVEY

The Anne Arundel County Health Department has put into operation, in Glen Burnie, the first station for the Metropolitan Baltimore Air Quality Survey. Being conducted by the State, Baltimore City, Baltimore County, and Anne Arundel County health departments, the survey is part of a three-year study under a grant of approximately $1,000,000. The grant provides $3 in federal money for each $1 from the participants in the study.

PROVISIONAL VITAL STATISTICS—1965

Maryland's birth rate in 1965 dropped approximately 8% below the 1964 rate to 20.9 per thousand population, according to provisional statistics compiled by the State Health Department. Declines were registered by every county and Baltimore City. During 1965, 74,000 children were born to Maryland residents, approximately 5,000 fewer than in 1964. This is the lowest number since 1956 and is typical of the national trend.

The death rate increased about 1% over 1964's record low, with 8.6 deaths per thousand population in 1965. The provisional figure was 30,671 deaths, approximately 1,000 more than in 1964.

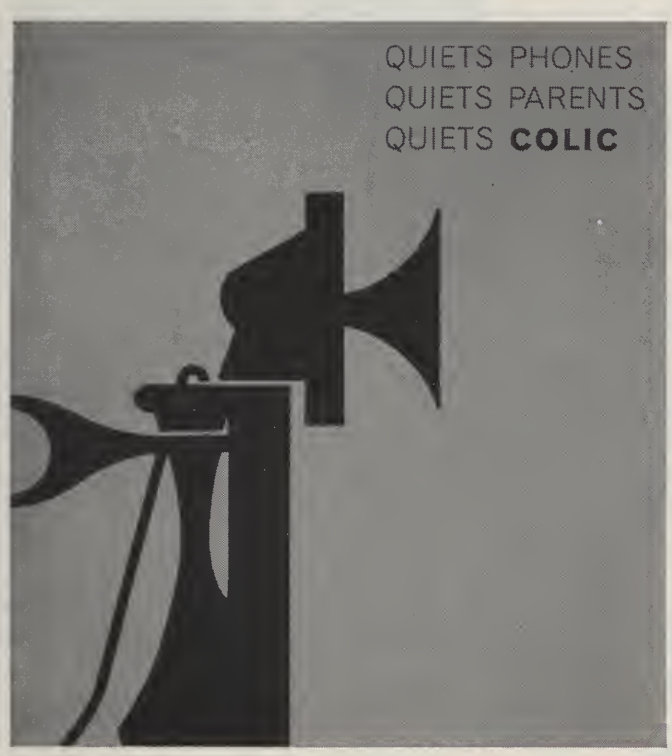
Heart disease, cancer, and stroke still lead as death causes in Maryland; death rates from each rose slightly in 1965. Greatest increase in death rates occurred as the result of influenza and pneumonia, motor vehicle accidents, and cirrhosis of the liver.

More information is available from the State Health Department's Division of Statistical Research and Records.

OBSTETRICAL CONSULTANT APPOINTED

King B. E. Seegar, Jr., MD, was appointed obstetrical consultant in the Bureau of Preventive Medi-

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



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cine. He has served part-time for the past year and a half as a consultant in the Department's maternal and child health program.

Upon request, Dr. Seegar offers consultation and assistance to local health officers and physicians in developing and improving obstetrical and family planning clinics. He has been cooperating with local health departments and community organizations, adapting his services to the particular needs of each community, as part of the Department's concerted effort to provide better prenatal and postnatal care for mothers who cannot afford private physicians. Information and guidance on family planning also are offered.

Dr. Seegar is a graduate of the University of Maryland School of Medicine, is certified by the American Board of Obstetrics and Gynecology, and has engaged in the private practice of obstetrics and gynecology for 20 years. He is assistant professor in obstetrics and gynecology at the University of Maryland and an instructor at the Johns Hopkins University School of Medicine. He is a former chief of obstetrics at both South Baltimore General Hospital and Church Home and Hospital.



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

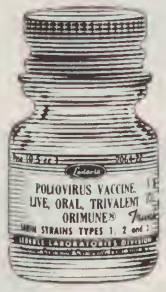
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



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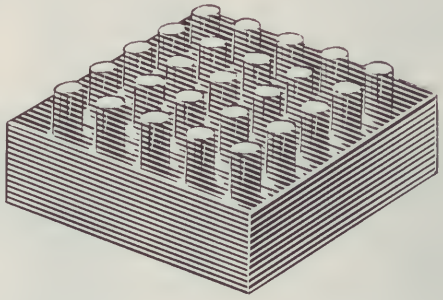


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In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.
Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months). Booster immunization: one dose, given orally. See package literature for full directions.



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Side effects are possible but rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available in boxes of 5 (new individually-capped unit); cartons of 25.

*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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Dental Health in Baltimore

Dr. H. Berton McCauley, director of the Bureau of Dental Care, reports that the dental health of the people of Baltimore, though far from perfect, is vastly improved over that of a decade ago. The improvement is the outcome of the continuous program of fluoridation of the public water supply.

Inaugurated by the Bureau of Water Supply on November 26, 1952, the fluoridation program has reduced tooth decay in resident Baltimore children by about 60% through age 11, 50% through age 13, and 30% through age 15. This represents about half a million fewer cavities in the teeth of the city's children and another 200,000 fewer in those of the surrounding counties. The economic advantage to parents in the metropolitan area served by the water system is conservatively valued at $3.5 million in dentists' bills alone. The benefits in improved teeth, health, and appearance are incalculable, yet the cost of fluoridating Baltimore's public water supply is only about $100,000 a year.

Recent evidence of the effectiveness of fluoridation was derived from a study of dental findings in 437 Head Start children in East Baltimore last summer. More than 50% of these underprivileged youngsters were entirely free of tooth decay, compared with 20-25% in random groups of Baltimore children of the same age in 1951.

A further indication of fluoridation's beneficial effects is that 17% of 2,385 prospective mothers who sought help in the Baltimore Maternity Center during the last six months of 1965 did not need dental care. As a rule, nearly all adults in similar circumstances need dental care.

Robert E. Farber, MD
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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

The Mental Health of the Negro

Maryland's nonwhite admission rates to psychiatric facilities are significantly higher than comparable white rates. The table, based on data from the Maryland Psychiatric Case Register, shows admission rates (per 100,000 estimated population) for the 1964 fiscal year by race, sex, and type of facility. These figures are consistent with comparable rates for 1963.

Type of Facility	WHITE			NONWHITE		
	Total	Male	Female	Total	Male	Female
DMH hospitals	199.9	246.8	153.8	373.9	487.3	263.6
Other public hospitals	62.0	69.8	54.3	46.0	70.3	22.3
Private hospitals	112.8	84.6	140.5	3.8	3.9	3.8
Total hospitals	374.7	401.2	348.7	423.7	561.5	289.7
Outpatient facilities	350.3	375.8	325.2	461.5	463.3	459.8
Total	725.0	777.0	673.9	885.2	1024.8	749.5

During this period, nonwhite admissions to the Department's six psychiatric hospitals were proportionally nearly twice the number of white admissions. This ratio was similar for males and females. Admissions to other hospitals for the treatment of mental illnesses significantly changed this comparison. These facilities reported few nonwhite admissions, particularly to the private hospitals (22 as compared with 3,221 white admissions). Nonwhite admission rates to all hospitals were 13% higher, with male rates 40% higher and female rates 17% lower than comparable white figures. Nonwhite admission rates to all inpatient and outpatient facilities were 32% higher among males and 11% higher among females. It is interesting to speculate as to the factors in the male and female role in the white and nonwhite family and community which produced the above differences. For example, is the lower hospital and the higher clinic rate among nonwhite women related to a more dominant female role in the economic structure of the Negro family?

It should be clear that these figures, and similar data reported from other states, cannot provide any indication as to the relative frequency of mental illnesses among the white and nonwhite population segments, since they pertain only to patients receiving treatment in specified facilities. The number untreated or receiving services through alternative resources, such as private psychiatric practice, is not known.

These data do fortify one important point. The tremendous cost to the community in terms of crime, delinquency, welfare, and other related problems stemming from the Negro's chronic cultural, economic, and social deprivation has been repeatedly pointed out. A number of interrelated factors are believed to be responsible for the greater utilization of psychiatric facilities by the nonwhite community. Among these, the above here also assume a key role.

Kurt Gorwitz

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Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

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For most physicians, a checking account, whether it be for his practice, for investments, or for household use, should provide three advantages: 1) a convenient way to pay bills, 2) a simple means to keep track of income and expenditures, and 3) a basis for rapidly verifying income and calculating deductible expenses for his income tax. Unfortunately, the latter two goals are seldom attained.

Whether you, an aide, or your wife handles the checkbook, confusion at the end of the month is probably the rule. No matter how meticulous you try to be, when you begin the job of reconciling your cancelled checks against your checkbook balance and the bank's balance, you generally are hoping: 1) you won't find a cancelled check which you forgot to enter, thus reducing the amount you thought you had as a balance; 2) the bank report will show you have more money in the bank than you thought you had.

The latter rarely happens. The former too often does. Also, in at least one month out of three, your excitement of reconciling to a perfect balance is shattered when you find you're off by some ridiculous figure such as $2.43 or 81 cents.

As for your record of deductible expenses, few doctors realize that the Internal Revenue Service does not always consider a cancelled check as proof of an expenditure. Since the burden of proof for legitimate deductible expenditures always rests with the taxpayer, a receipt with a cancelled check is the best evidence to present if your income tax return is called for an audit. (Since the installation of computers, the IRS is performing more and more audits each year.)

The following simplified checkbook and accounting procedure is recommended for physicians.

1. Obtain the three checks to a page, business-type checkbook from your bank.
2. Make sure you deposit all cash and checks into your practice checking account. Deposit all interest, rents, dividends, and money from the sale of investments into your investment accounts. Try to predetermine a budget for household expenses and make timely deposits.
3. Insist on bills or receipts for disbursements which may be questioned later.
4. Mark all check stubs with adequate information describing in full the purpose for which the check was drawn.
5. When deposits are made, be sure the correct amount is recorded on the checkstub. Tape the copy of the deposit slip to the reverse side of the checkstub for future reference.
6. When writing and numbering a check, place the same number upon the bill or receipt and place this bill in the back of the checkbook temporarily.
7. When the cancelled checks are returned from the bank, attach each check to the appropriate stub with scotch tape. Then, from the back of the checkbook, take the bill or receipt for which the check was written and attach it to the cancelled check.

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nal Revenue audit can be conducted quickly and accurately, and a great deal of confusion can be avoided when reconciling expenditures. (A duplicate system should be used for separate bank accounts maintained for investments and household purposes.)

By keeping receipts, bills, and cancelled checks in your checkbook, you may find you've taken on more bulk than you have room for. An alternate method is to keep your receipts, bills, and matching cancelled checks in envelopes or file folders appropriately marked as to their contents.

illustration after Boyden



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The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

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INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

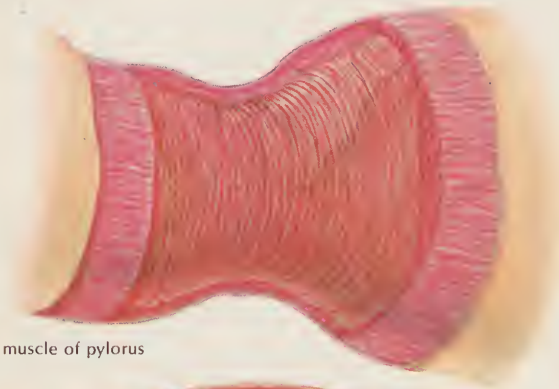
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smooth muscle of colon



smooth muscle of pylorus



smooth muscle of uterus



smooth muscle of urinary bladder

MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

Annual Meeting of Maryland Association of Medical Assistants

The Maryland Association of Medical Assistants will hold its annual meeting in the Blue Room of the Sheraton Belvedere in Baltimore on Saturday, April 30. For two days preceding the meeting, members of the group operate a coffee booth for the benefit of the Medical and Chirurgical Faculty of Maryland, whose annual meeting this year is April 28 and 29 at the Alcazar. The health evaluation survey offered to physicians during this meeting is also aided by the medical assistants.



The MAMA Coffee Bar is a popular spot at the Alcazar during the annual meeting of the Medical and Chirurgical Faculty. Coffee and cookies will be served again this year on April 28 and 29.

Program for the April 30 meeting is as follows:

A.M.	
10	Morning registration
10:30-12	Business meeting
P.M.	
12-1	Lunch and afternoon registration
1:15	Welcoming address
1:30-2:15	THE USE OF THE VACUUM EXTRACTOR IN OBSTETRICS Eleanor Scott, M.D., Chief of Obstetrics, Church Home and Hospital
2:15-3:00	CARDIAC PACEMAKERS J. M. Zimmerman, M.D., Chief of Surgery, Director of Medical Education, Church Home and Hospital; Associate Professor of Surgery, Johns Hopkins University

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4:15-5:15 SPACE MEDICINE
Frank B. Voris, M.D., Captain, Medical Corps, U. S. Dept. of Navy

The program will conclude with a cocktail hour at 6 P.M. and a banquet at 7. The master of ceremonies will be Raymond M. Atkins, M.D., instructor in anatomy and surgery, University of Maryland; instructor, outpatient vascular clinic, Johns Hopkins Hospital; assistant director of Medical Education, Church Home and Hospital.

Members and non-members are invited to attend. Anyone interested please contact Mrs. Dorothy MacCubbin, treasurer, 5904 Roland Avenue, Baltimore, Md. 21210, or call 539-5669.

Woman's Auxiliary

April, 1966

MRS. IRVING J. TAYLOR, *Auxiliary Editor*

Regional Vice President Will Speak At Auxiliary Luncheon

An honored guest and speaker at our state auxiliary's annual convention will be Mrs. Erle E. Wilkinson, vice president of the Southern Region, Woman's Auxiliary to the American Medical Association.



Mrs. Erle E. Wilkinson

The convention will be held April 27 and 28 at the Holiday Inn Downtown. Mrs. Wilkinson will address the luncheon gathering on the 28th.

Betty Wilkinson is serving her first term as a regional vice president, having completed a three-year term as national chairman of the AMA-ERF Committee.

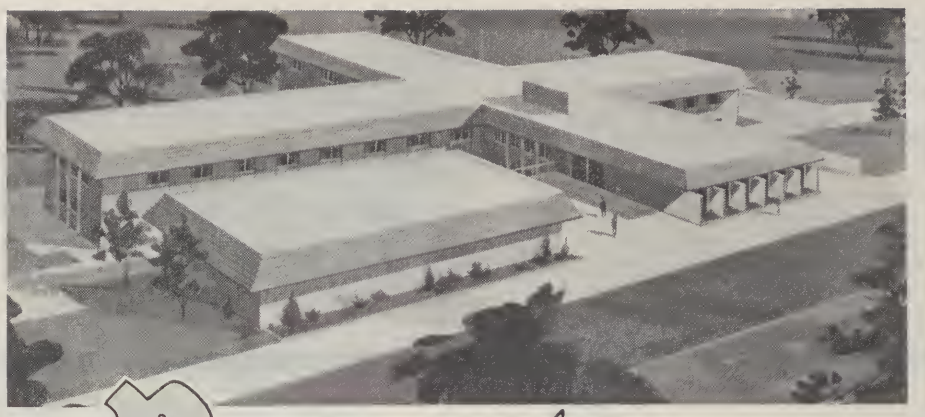
A resident of Nashville, Tenn, she is a past president of her state auxiliary and is currently its parliamentarian. She has held numerous other posts in her state and county auxiliaries.

Mrs. Wilkinson is a nursing graduate from Vanderbilt University. She has taught Red Cross Home Nursing and Nurse's Aide classes for the Red Cross and is a former instructor in nursing arts and medical nursing at the John Sealy Hospital, Galveston, Tex. Her husband is a pediatrician in Nashville.

President's Message

by ***NORMA M. STROBEL***

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We especially want to welcome the following new members-at-large—all from Anne Arundel County—who have joined the auxiliary recently: Mrs. J. Howard Beard, Gambrills, Mrs. Richard I. Hochman, Annapolis, Mrs. Joseph C. Sheehan, Severna Park, Mrs. Donald C. Smith, Annapolis, Mrs. Willard Smith, Shady Side, and Mrs. William N. Thomas, Severna Park. We hope that they will seriously consider organizing a component auxiliary in Anne Arundel County.

It behooves each doctor's wife to become well informed about the medical world. She should try to learn as much as possible so that she may interpret the information to others. It is important that her friends and her community understand the physician's viewpoint. She is the main liaison between her husband and the world he lives in. She must act as an ambassador in her community to create a realistic picture of medicine as a profession. She must set an example for those with whom she comes in contact concerning such things as the rearing of children and promoting good health habits.

There has been an increasingly negative reaction on the part of the public to the medical profession. Physicians have seemed to be aloof and anti-social in their attitude toward economic change. We must, therefore, have a more positive approach to present problems. Health education and preventive medicine are more important than treatment when it is too late.

Let us all resolve to do our best to correct the image of the physician in the eyes of the general public. Will you accept the challenge?



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APRIL 27 and 28, 1966

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A MEDICO-LEGAL PROBLEM: REFERRING PATIENTS OF ONE DOCTOR TO ANOTHER

The Committee on Medico-Legal Problems has received several complaints from physicians directed against attorneys who have referred patients from one physician to another physician. Lawyers should note that the procedure of a physician accepting a patient already under treatment by another physician is remarkably similar to that of an attorney taking the case of a client already represented by counsel.

While the client/patient has a perfect right to change practitioners the second practitioner is under an obligation to ascertain whether the patient is under treatment and if so, if the first practitioner has released the patient/client.

When a lawyer refers a patient to a second physician, without the consent of the first physician, he interrupts the treatment by the first physician and places the second physician in an unethical position which may result in a censure or other disciplinary action.

Lawyers should be aware of this problem and should be mindful to avoid any advice or action which may contribute to, or result in, unethical conduct on the part of physicians.

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THE APPLICATION OF NEUROLEPTANALGESIA IN ANAESTHETIC AND OTHER PRACTICE, edited by N. W. Shephard. Pergamon Press, 1965. $8.50

This is a symposium debating the effectiveness and place of Phenoperidine, Droperidol, and Fentanyl in anesthetic practice today. The debate covers the subject of neuroleptanalgesia, which is a state produced by the combined use of a neuroleptic drug such as Droperidol and an analgesic, for example Phenoperidine. The papers published in this volume will be of interest to all concerned with anesthesia and the surgical and pharmacologic aspects of medicine.

ADVANCES IN OXYTOCIN RESEARCH, edited by J. H. M. Pinkerton. Pergamon Press, 1965. $10

This volume contains the proceedings of a symposium held at the Royal College of Obstetricians and Gynaecologists, London.

Oxytocin was chosen as the subject of this symposium for two reasons: 1) because important work has been done recently on its physiology and pharmacology, and 2) because a new method of administering the drug for the induction of labor in women has become available. It therefore seemed desirable to discuss this new work as a whole. The proceedings published in this volume represent a variety of points of view, and should be of interest to all involved in the study or clinical use of oxytocin: biochemists, physiologists, anatomists, pharmacologists, endrocrinologists, obstetricians, gynecologists, and biologists.

COMPENSATORY ADAPTATIONS, REFLEX ACTIVITY, AND THE BRAIN, by Ezras Asratovich Asratian. Pergamon Press, 1965. $15

This is the first of a series of carefully selected and edited English translations and surveys of Russian contributions in the fields of conditioned reflexes and cerebrovisceral and behavioral physiology. Dr. Asratian, one of Pavlov's outstanding students, summarized the results of nearly twenty years of intensive research on the role of the cerebral cortex in the compensation of disturbed functions of the musculoskeletal system and in regulation of visceral and endocrine functions. He reports the results of extensive experiments designed to explain the many complex mechanisms underlying the development of conditioned reflexes and the adaptation of higher organisms to an ever-changing environment. The book includes a lucid description of direct and reverse or backward conditioning, the results of switching in conditioned reflex activity, and the localization of cortical inhibition in the conditioned reflex arc.

It has been translated by Dr. Samuel A. Corson, a professional bilingual scientist who is directing an active research program in the field of conditioned reflexes and of cerebrovisceral and behavioral physiology. In his

preface, Dr. Corson offers an illuminating summary of the historical and philosophical background of Russian biomedical thinking as exemplified in the theory of nervism or the neurogenic theory of medicine.

This book should be of interest to physiologists, neurologists, psychiatrists, psychologists, and physicians interested in problems of psychosomatic medicine and of restoration of neuromuscular functions. It may be used as a reference in courses in experimental and physiological psychology, neurophysiology, physical medicine and rehabilitation, neurology, and psychiatry.

PEDIATRIC THERAPY, ed 2, edited by Harry C. Shirkey, MD. Mosby, 1966. $18.50

While therapy is the emphasis of this volume, precise diagnosis is stressed throughout, since each is useless without the other. Complete treatment of the child is encouraged: medical, dental, surgical, and psychiatric. Many new chapters appear in this edition, including consideration of pediatric orthopedics, neurosurgery and psychiatric care. The Table of Drug Dosages has been enlarged, thus omitting needless repetition of this information in individual chapters.

GASTROENTEROLOGY, vol 3, ed 2, by Henry L. Bockus, MD, et al. Saunders, 1965. $30

Volume III of this work comprises discussions of gastrointestinal parasites, the liver, biliary tract, and pancreas, and secondary gastrointestinal disorders. The contributors are Dr. Bockus's colleagues and former colleagues at the University of Pennsylvania Graduate School of Medicine.

This entire edition has been rewritten, shifting emphasis where necessary and presenting new techniques and new knowledge of clinical import. Ample use has been made of illustrations to show the many new techniques and procedures.

NEURO-OPHTHALMOLOGY, vol II, edited by J. Lawton Smith, MD. Mosby, 1965. $21.75

This volume presents the material discussed at the second postgraduate symposium on clinical neuro-ophthalmology sponsored by the Department of Ophthalmology, University of Miami School of Medicine. The papers represent the current interest of each of the participants.

HANDBOOK OF PHYSICAL MEDICINE AND REHABILITATION, edited by Frank H. Krusen, MD. Saunders, 1965. $16.50

The American Rehabilitation Foundation, in 1957, established a Medical Advisory Committee to advance the field of physical medicine and rehabilitation and develop adequate teaching programs in the medical schools. This handbook is one of the contributions of this committee. In three parts, it covers evaluation of the patient, techniques of management, and evaluation and management of specific disorders.

SYMPOSIUM ON THE LENS, by John E. Harris, MD, et al. Mosby, 1965. $18.50

The organizers of this symposium, envisaging a publication having the scope of a textbook, asked each participant to review all the knowledge in his particular field. Thus, this volume surveys up-to-date information on the anatomy, biochemistry, physiology, immunology, and other aspects of the normal lens.

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CURRENT SURGICAL MANAGEMENT III, edited by Edwin H. Ellison, MD, Stanley R. Friesen, MD, and John H. Mulholland, MD. Saunders, 1965. $11.50

One hundred and four surgical authorities have contributed their viewpoints on controversial surgical problems. In some instances the viewpoints vary because of fundamental differences; in others, the disagreement concerns the choice of or timing of an operation. The topics selected are those in which acceptable controversy exists and which represent questions which commonly beset a surgeon. While not providing any answers, it shows how certain authorities have arrived at their own solutions.

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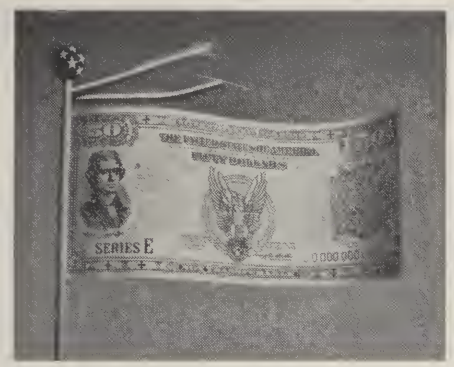
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St. Mary's Hospital, Leonardtown
Memorial Hospital, Easton
Washington County Hospital, Hagerstown
Peninsula General Hospital, Salisbury

MEDIC programs may also be heard at headquarters of the following cooperating organizations: the Medical and Chirurgical Faculty of the State of Maryland, the Maryland State Department of Health, the Hospital Council of Maryland, Inc.

Appropriate AAGP credit is given for every MEDIC program attended.

See Page 7 for current program listings.

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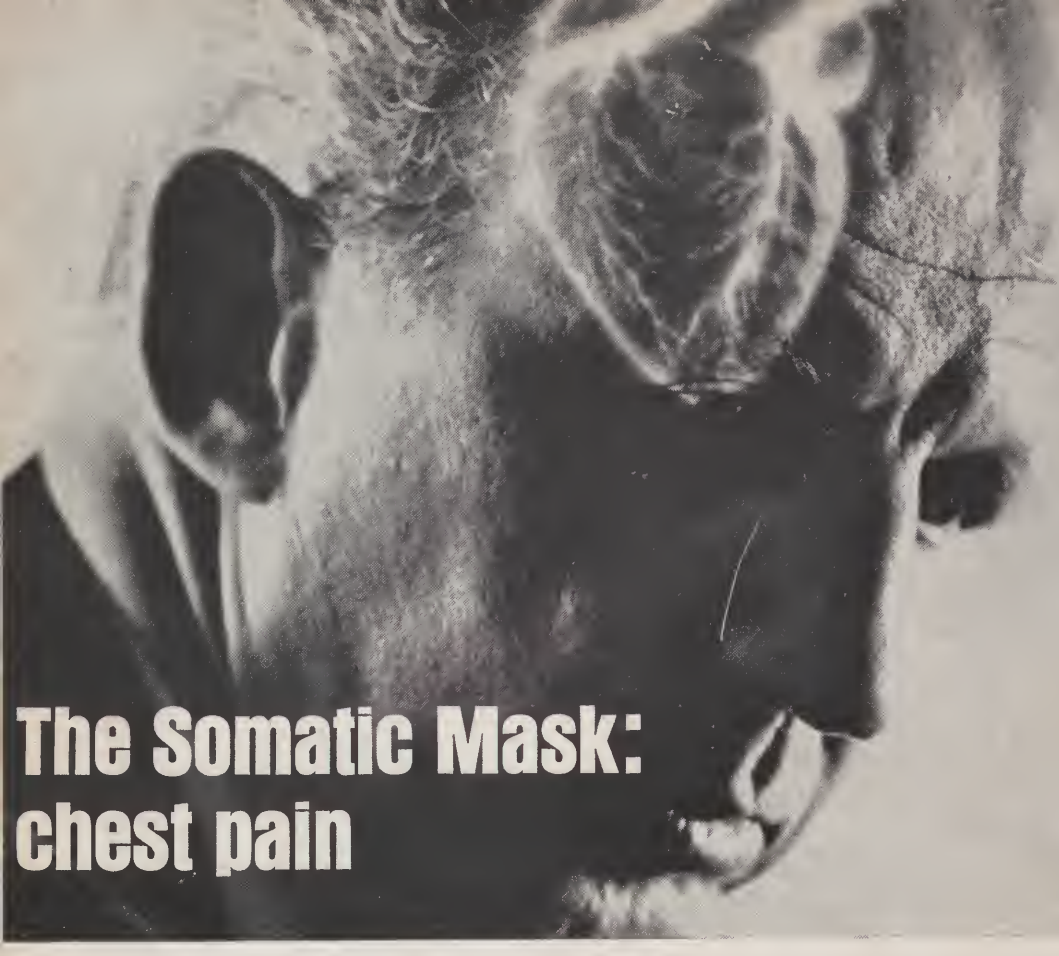
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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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Vol. 15 No. 5
May, 1966

Maryland
STATE MEDICAL JOURNAL



OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

INDICATIONS: Grand mal epilepsy and certain other convulsive states.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced.

SIDE EFFECTS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Upon discontinuation of therapy eruptions usually subside. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Hematologic disorders, including megaloblastic anemia, leukopenia, granulocytopenia, pancytopenia, and aplastic anemia have been reported. Nystagmus may develop.

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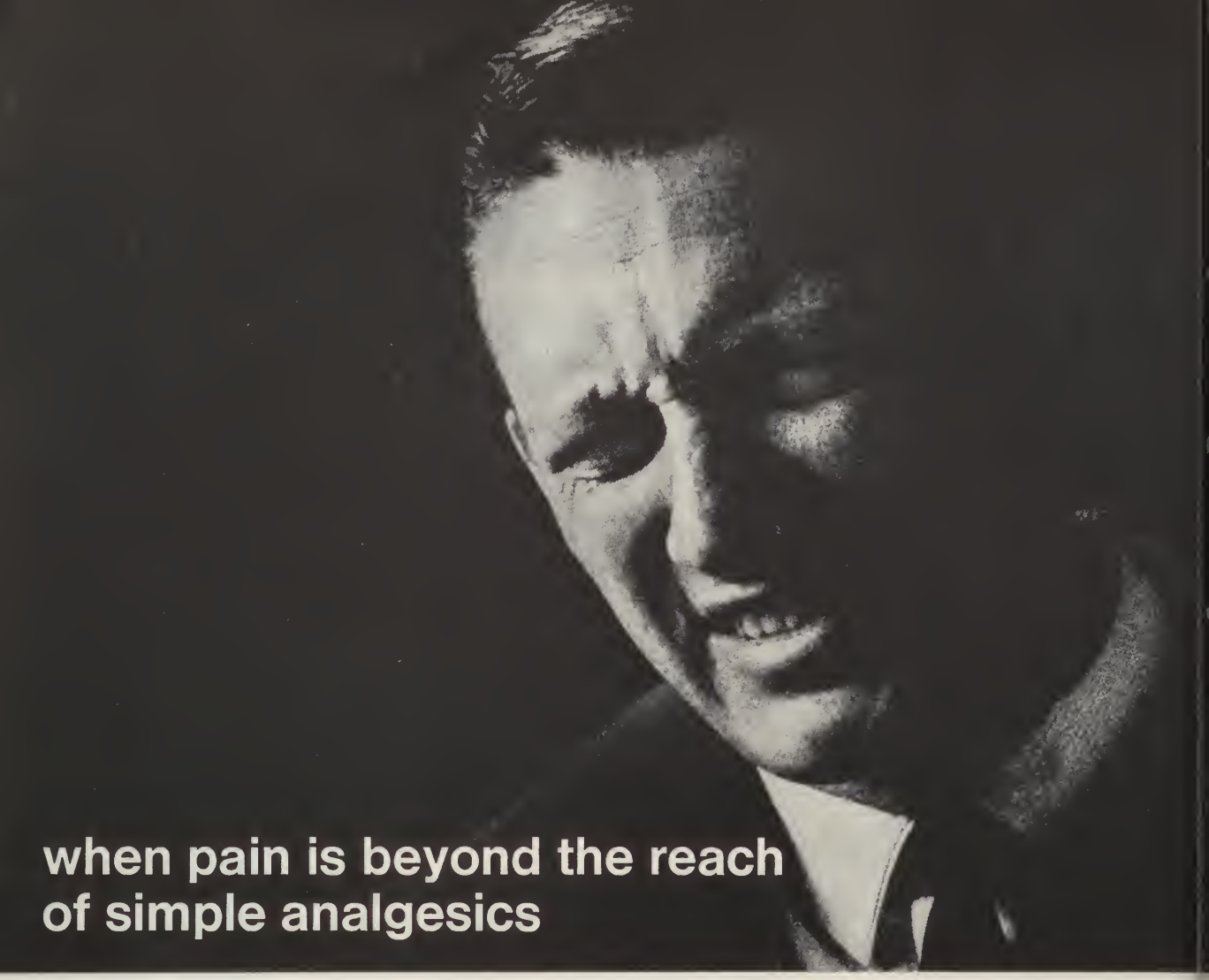
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Side effects have been minor. Occasionally gastric distress, weakness, sedation or dizziness occur. Reversible cholesta jaundice has been reported on rare occasions. However, in 4,653 patients treated with chlormezanone, 97.7% had *no* s effects.[1] *Contraindication:* just one: sensitivity to aspirin. *Dosage:* Adults, usually 2 tablets three or four times daily. Children (from 5 to 12 years), 1 tablet three or four times da.

1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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Maryland
STATE MEDICAL JOURNAL

Vol. 15, No. 5
May, 1966

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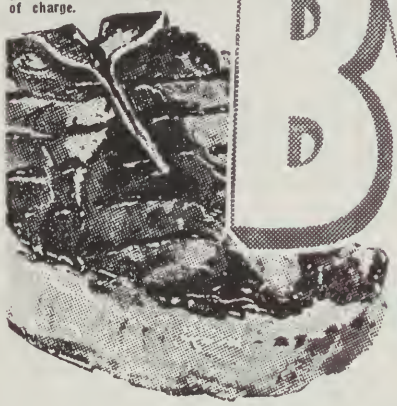
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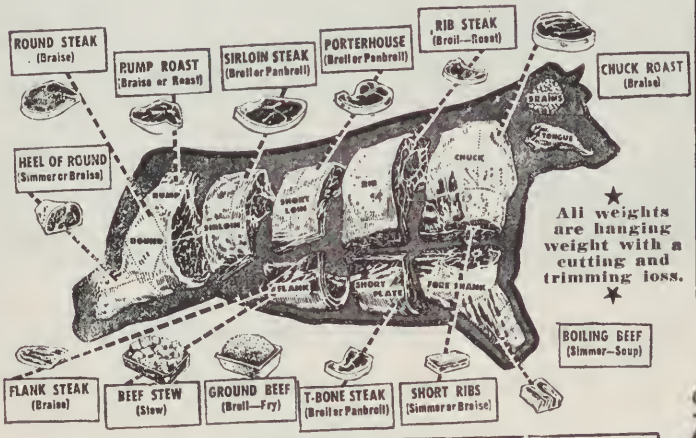
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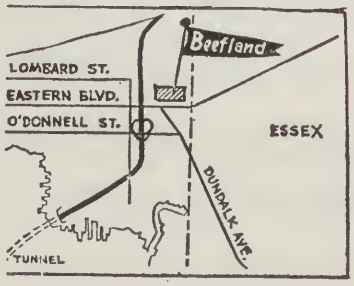


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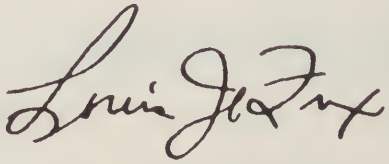
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Doctors take note...

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May 27—1-2 PM

From Frederick Memorial Hospital: "Blaad Transfusians," Julius R. Krevans, MD.

June 10—12:30-1:30 PM

From The Johns Hopkins Hospital: "Alcohalic Cirrhosis," Frank L. Iber, MD.

June 24—1-2 PM

Fram Frederick Memarial Haspital: "Palycythemia Vera," C. Lackard Canley, MD.

Yau may hear these programs in the Faculty auditarium ar at ane of the participating hospitals (see Page 160).

AMERICAN THORACIC SOCIETY

May 23-25—San Francisco

1966 Annual Meeting. Cantact: James Kieran, MD, chairman, Medical Sessians Committee, American Thoracic Saciety, 1790 Braadway, New Yark, NY 10019.

AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

June 25—Conrad Hiltan Hatel, Chicago

Contact: Seymaur Diamond, MD, secretary, 5214 N Western Avenue, Chicaga, Ill. 60625.

HEART ASSOCIATION OF MARYLAND

June 2-3—Ocean City

CHAMPS spring sessions

POSTGRADUATE COURSES

AMERICAN COLLEGE OF PHYSICIANS

Caurse Na. 18—ADVANCED PSYCHIATRY FOR THE INTERNIST, June 13-17, Baltimore Psychoanalytic Institute and Psychiatric Institute of the University of Maryland.

Caurse Na. 19—NEUROLOGY FOR THE INTERNIST, June 16-17, Bowman Gray Schaal af Medicine af Wake Farest College.

Contact: Edward C. Rasenow, Jr., MD, executive directar, The American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

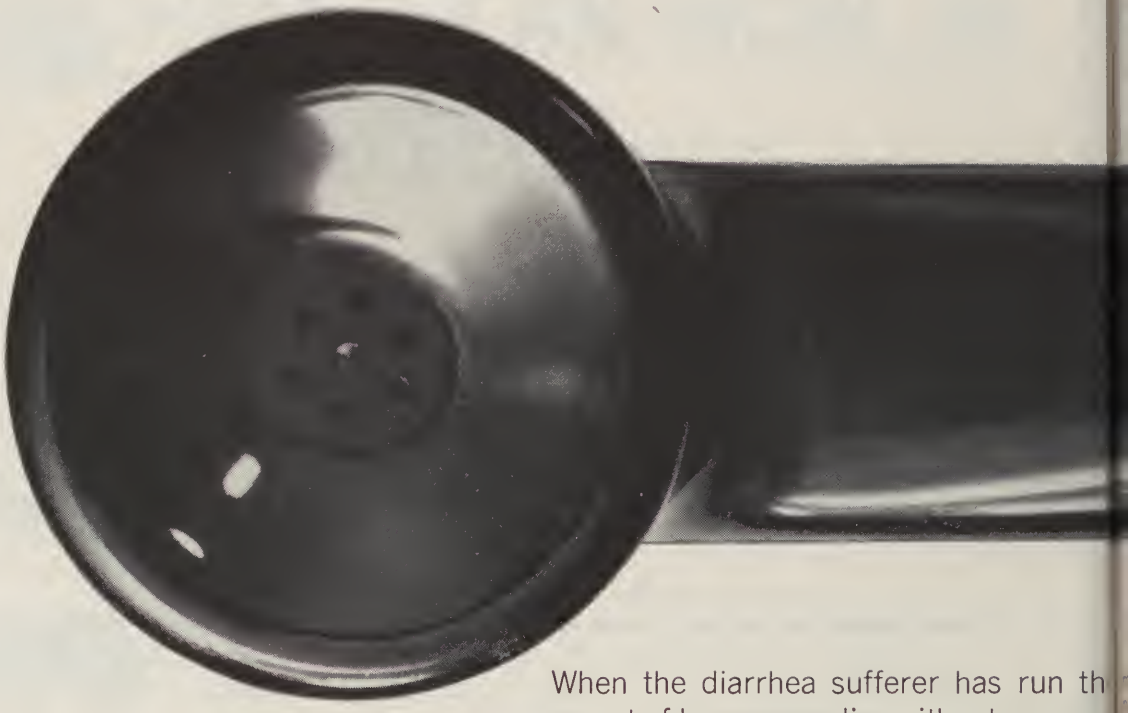
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Interpretation and Therapy of Cardiac Arrhythmias, July 25-29, Marriott Matar Hatel, Philadelphia. Leonard S. Dreifus, MD, director.

AMERICAN COLLEGE OF CARDIOLOGY

Nine-month tutarial program in Cardiology, September 15, 1966 to June 15, 1967. Contact: Executive Secretary, Institute for Cardiapulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, Calif.

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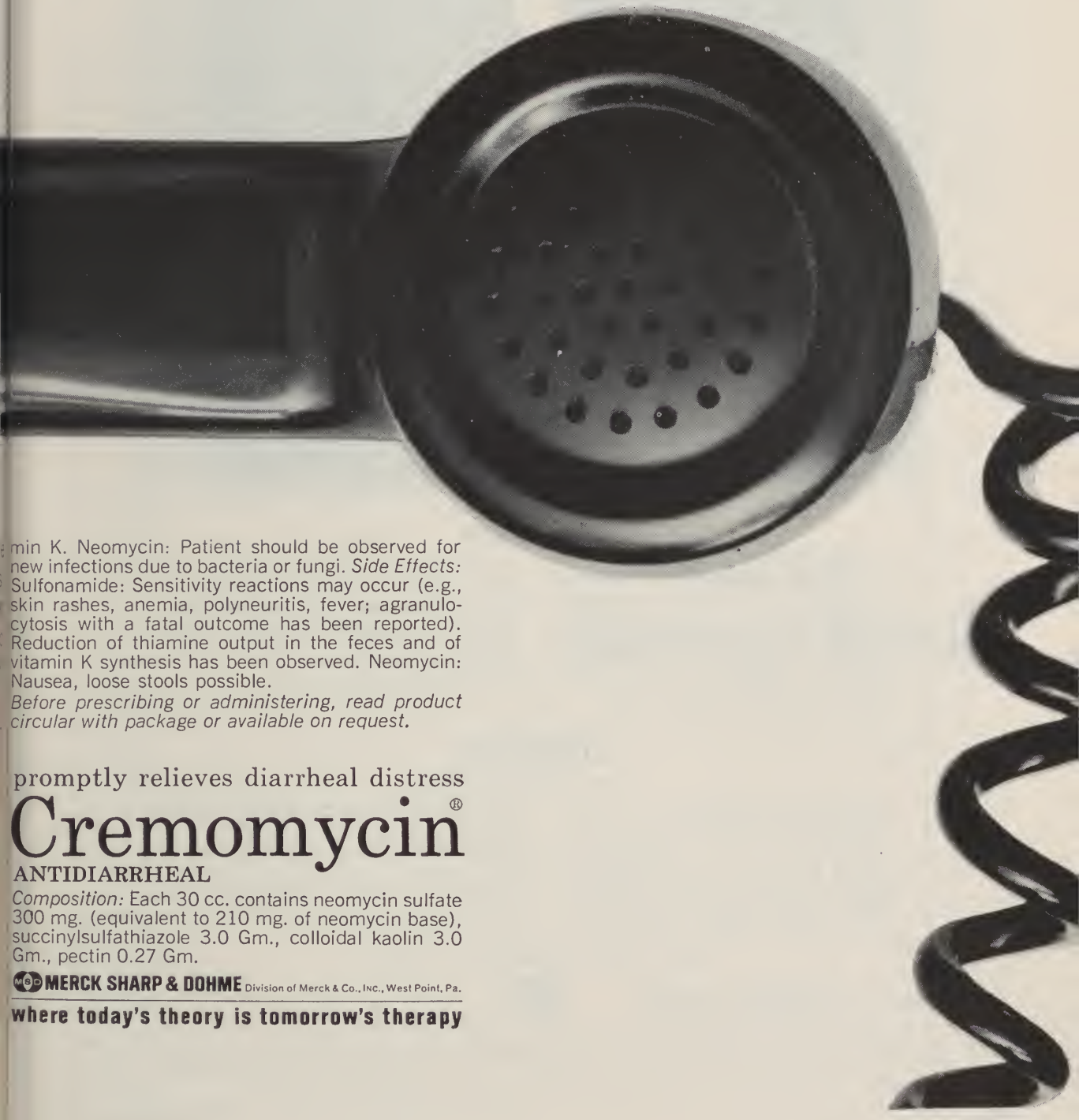


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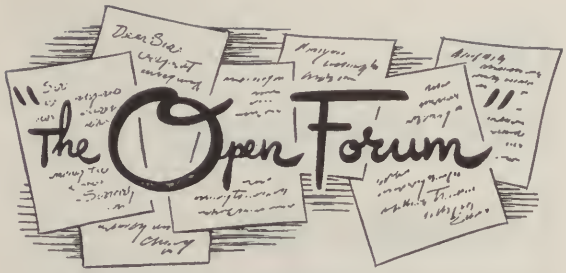
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To The Editor:

Cases 8 and 9, Anesthesia Accidents, on the Maternal Welfare pages of the Maryland State Medical Journal (Vol. 15: 19-20, January, 1966) merit comment. Although it is implied that the first patient succumbed to an inadvertent subarachnoid anesthesia during an attempted caudal anesthesia, the facts available do not necessarily support this. Local anesthetic drugs have been consistently demonstrated in the cerebral spinal fluid after properly administered epidural block. The actual dose of the drug metycaine is not indicated in the protocol. If 20cc. of 1.5% (usual concentration) metycaine had been injected into the subarachnoid space, the dose would have been 300 mgm. We note that 25 minutes after the beginning of anesthesia and 15 minutes after the completion of the injection, the blood pressure was 140/100 and the pulse strong and regular. This would not have been the case if the patient had received such an overwhelming dose in the subarachnoid space. Five minutes later, 20 minutes after the completion of the injection, the patient showed signs of distress—labored respirations, irregular and feeble pulse, restlessness. This might very well have been a local anesthetic drug reaction, but it may even have been related to hypotension from the supine venacaval syndrome. Regardless of the initiating factor, the injection of 1 mgm. (presumably 1cc. of 1:1,000 adrenalin) would very likely have sufficed to cause ventricular fibrillation in this hypoxic, hypotensive patient. This misdirected resuscitative effort was the last straw which put the lid on this patient's fate.

Aspiration of vomitus is the most frequent cause of obstetric anesthesia mortality. It seems that this patient was given a general anesthesia without concern as to recent ingestion of food. Only after aspiration of vomitus was the chief anesthetist called. This arrangement seems to have the blessing of obstetricians and anesthesiologists alike in many, many hospitals.

We should not mislead our reading audience by suggesting that gastric lavage after a recent meal is effective and that it will render the patient safe for general anesthesia. No technique of emptying the stomach (lavage, apomorphine) has been demonstrated to be reliable, and this particular patient would only have been safe with an endotracheal tube in place. This could have been safely accomplished under topical anesthesia, or, in expert hands, following a crash induction with thiopenthal and succinylcholine. Even here, there is always the chance that the patient might regurgitate before insertion of the tube. There seems little justification for imposing any such hazard on a para 5 gravida 6 patient anticipating a normal delivery, and who probably would be alive today with no contributions from obstetric and anesthetic personnel.

Anesthesia is one of the leading causes of obstetric mortality, and the relative contribution is increasing. This trend can only be corrected through critical analysis of the mishaps occurring.

Otto C. Phillips, MD

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Maryland State Medical Journal
Vol. 15, No. 5
May, 1966

Editorial

Presidential Editorial

J. MORRIS REESE, MD

Despite journalistic intimations otherwise, the medical profession is still considered an important opinion-molding force in the minds of most of the lay public. The people are interested in what their doctor has to say on legislative affairs even when, as in the case of PL 89-97 (Medicare), there was far from unanimity in medical ranks.

Governmental leaders are also intensely occupied in gaining the cooperation of this cogent segment of national leaders, for without the advice and statesmanship of doctors, the Medicare program will not work. This is why representatives of the American Medical Association have been importuned to work with Social Security to ensure that Medicare will be implemented with the least possible disruption by those who can make it work.

This statesmanship on the part of the medical profession is recognized as just that on all levels from that of the federal government to the local bailiwick. The Medical Chirurgical Faculty works constantly with state agencies, voluntary health associations, professional groups, and insurance representatives for the public welfare on any level.

In the state legislature, consultation is sought and carefully heeded so that physicians' opinions on matters of importance to Maryland residents may be determined. Doctors are asked to appear at public hearings on matters which are not narrowly defined as physician-oriented. The medical man is considered an educated citizen in more than one small sphere, and his advice is so solicited.

In all instances the cooperation of the medical profession in the public weal is immense and



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Apparently, however, this is no longer enough. We are constantly being advised by self-seeking dissidents to "heal thyself doctor." Instances of almost miniscule corruption within the ranks are being used to tar a whole profession. And rather than to ignore these complaints, it behooves us to face the dissension within our own ranks and the slings and arrows of all who would bid us to re-examine our health.

We are not adverse to such self-examination. Through the Faculty, we are indeed seeking ways to strengthen the body medical. For instance, in areas of self-discipline we could well take a tip from the Bar Association which, under rules established by the courts, has authority to investigate and bring charges against members and nonmembers. Actual disciplinary action is meted out by the court itself. Perhaps a self-examination will reveal that the Maryland medical profession needs more authority to move against the few whose unethical conduct leaves the entire profession open to criticism.

Frank, honest opinions should be expressed through the democratic processes available to members on the component level. But these opinions serve nothing but a self-serving interest when based on unknowledgeable or biased points of view. If the individual physician has honestly and without bias given time to his medical society committees; if he has given due and scientific study to intrasociety problems; if he truthfully feels that he has exercised all opportunities available for expression of his viewpoint through the channels available to him, then his opinion may be considered studied and authoritative.

What is needed now, more than ever, is for the medical profession to police its own ranks and bring to task the few offenders against professional ethics, whether members or not. It is time to look consistently toward the public interest and away from purely selfish ones.

Let us consider carefully the following words from I Corinthians, 13th Chapter: ". . . Though I speak with the tongues of men and of angels and have not charity, I am become as sounding brass or a tinkling cymbal . . ."



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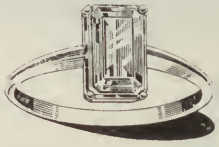
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EXECUTIVE SECRETARY'S NEWSLETTER

May, 1966

MEDICARE LAW

The attention of all physicians is directed to the following provision of the Medicare Law (PL 89-97) which reads as follows:

"Nothing in this title shall be construed to authorize any Federal Officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided or over the selection, tenure, or compensation of any officer or employee of any institution, agency or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

EDUCATIONAL PROGRAMS

In accordance with instructions from the House of Delegates, September, 1965, the Faculty plans to offer over the MEDIC network, a session dealing with implementation of the Medicare law.

In addition, plans are underway for regional sessions at which "in-person" discussions will take place. Initial arrangements are for programs to be held as follows:

Salisbury (Worcester, Wicomico, Somerset Counties)

May 9 - Physicians
May 10 - Office Assistants

Easton and Cambridge (Talbot, Dorchester, Kent, Caroline and Queen Anne Counties)

May 18 - Physicians, in Cambridge
May 19 - Office Assistants, in Easton

Harford Memorial Hospital (Harford and Cecil Counties)

May 26 - Physicians in morning
Office Assistants in afternoon

Allegany County

June 1 - Physicians
June 2 - Office Assistants in morning

Garrett County

June 2 - Office Assistants in afternoon
Physicians in evening

Frederick County (Carroll, Frederick and Washington Counites)

June 16 - Physicians in morning
Office Assistants in afternoon

Baltimore City - through Hospital Staff activities and through MEDIC and Faculty building

The MEDIC network program will be held following a national meeting on this subject scheduled for Chicago on Saturday, June 25.

SEMIANNUAL MEETING RESOLUTIONS

Resolutions for the Faculty's Semiannual Meeting scheduled for Ocean City, Md., on Friday, September 9, at the Diplomat Motel, must be in the Faculty Office no later than:

FRIDAY, JULY 15, 1966

Resolutions received after this date will be held over for the 1967 Annual Meeting.

AMA ANNUAL SESSION

The AMA meets in Annual Session, June 26-30, in Chicago, Ill. Members who are in Chicago and would like to tour the AMA building may do so daily from 8:30 a.m. on. The Biomedical Research Institute is included in the tour.

Members may contact the Faculty's Delegates to the AMA through the Palmer House, where delegates are registered.

NEWS NOTES

New Active Members of the American Society of Anesthesiology include: Juliana G. Del Rosario, M.D., La Plata; Jae Pil Lee, M.D., and Young Choon Hong, M.D., Baltimore; and new Junior Members: Sreela Banarjee, M.D., Bethesda; Jose Gomez Duarte, M.D., Claro L. LaVina, M.D., and Leticia Cawagas Quetulio, M.D., all of Baltimore.

John Sargeant

Executive Secretary

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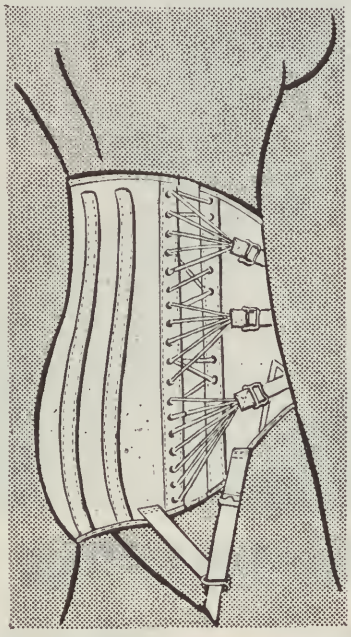
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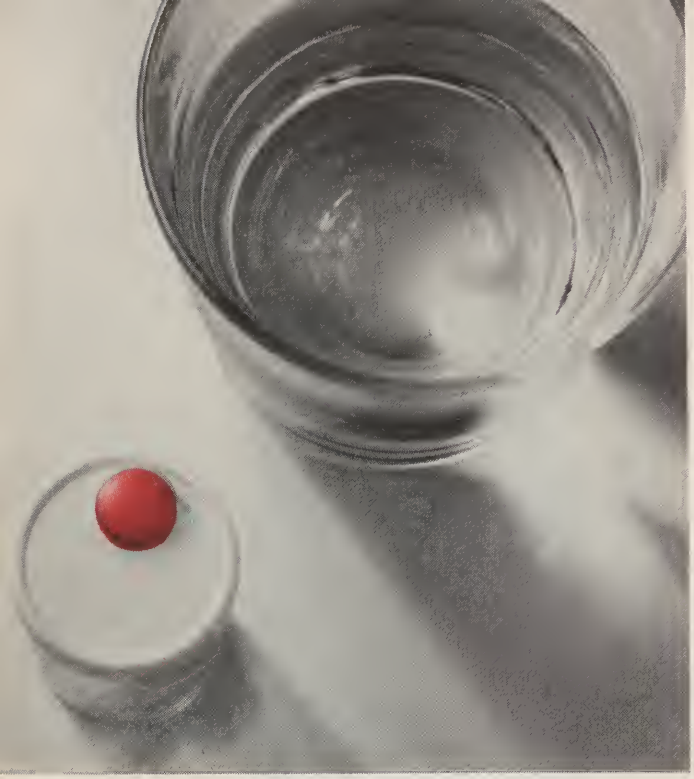


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Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, MARCH 17

1. Appointment of Raymond M. Atkins, MD, as advisor to Maryland Association of Medical Assistants was approved.

2. The State Health Commissioner requested that the Faculty send a representative to the Appalachia Conference on Health, April 21 and 22. Because of the press of Faculty activity right before the Annual Meeting, it was not possible to do so; however, the Commissioner is to be thanked.

3. Loan of certain historical items was approved for the auxiliary meeting of the American Society of Abdominal Surgeons.

4. The Faculty was authorized to become a sustaining member of the Maryland Public Health Association, subject to approval of the Treasurer.

5. Certain amendments are to be offered to the State Health Department concerning proposed rules and regulations for the operation of clinical laboratories. As amended, they are satisfactory to the Faculty.

6. The draft proposal concerning domiciliary and care home regulations was deemed satisfactory except for clarification of the reporting party.

7. The Executive Committee thought it not desirable for advertisers or solicitors to be permitted to take the Bermuda cruise, as this would enable them to engage in solicitation of physicians either formally or informally aboard ship. Such persons may take the trip on a space available basis as a vacation but not as business.

8. The Medical Eye Bank, Inc. is to be permitted continued use of Faculty facilities at no charge to them, but the handling of their business matters is to be done at the discretion of the office manager.

9. Faculty co-sponsorship of a statewide conference on Meals on Wheels was approved.

COUNCIL, MARCH 24

1. Payment of physicians' fees under the Medicare Law was discussed. The consensus was that the Health Department's Advisory Council on Medical Care will develop a schedule for use in arriving at budgetary figures for the medical care programs, providing for payment of "usual and customary" fees. This will be discussed with the Fee Schedule Committee and recommended for adoption by the Council.

2. A moment of silence was observed in memory of Albert E. Goldstein, MD.

3. Physicians Defense was ratified for members requesting it.

4. Report of a case settlement was noted.

5. Emeritus membership is to be recommended for Mary McK. Cushing, MD, Baltimore County, and Edith H. Weigert, MD, and Naomi Lucius, MD, Montgomery County.

6. Dues for 1966 were waived for a Baltimore City physician who is ill.

7. Financial statement and restricted fund statement through January 31 were approved.

8. A request to allocate up to $1,000 from the Educational Fund to pay out-of-pocket expenses of speakers representing the Speakers' Bureau Subcommittee was denied.

9. A recommendation made by the Committee on Postgraduate Education, Preventive Medicine, and Public Health concerning a recruitment council was not adopted, as one already exists. The

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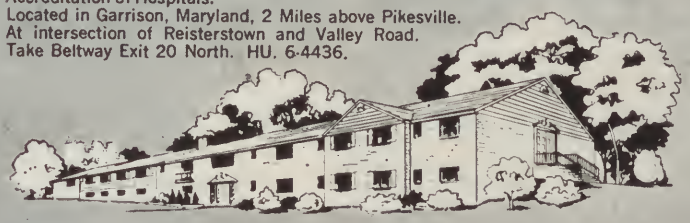
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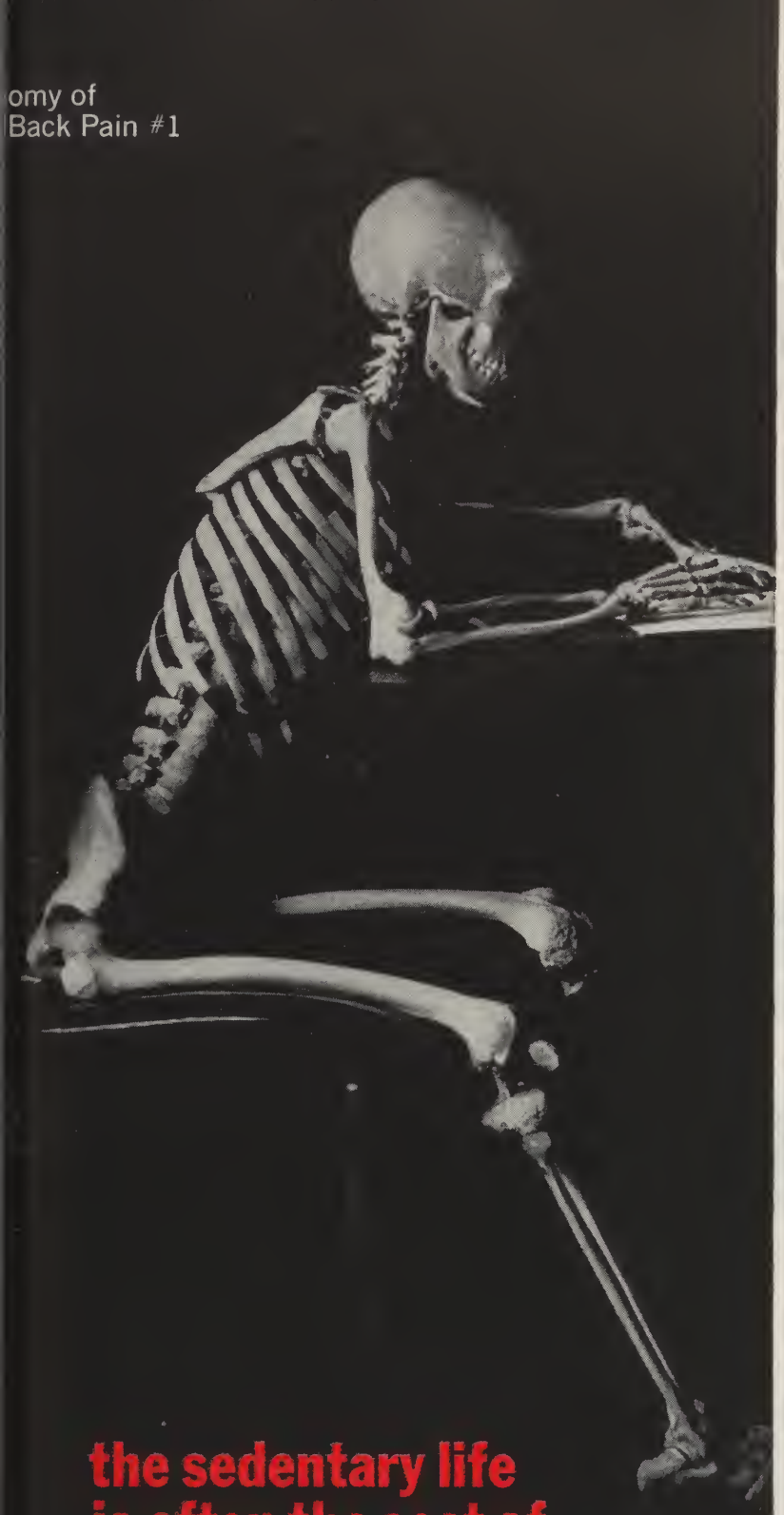
Committee is to be advised that the Council would consider a recommendation regarding medical and paramedical *placement.*

10. No action was taken concerning the proposed immunization program of the State Department of Health.

11. The Liaison Committee advised the Council, for its information, that the Health Department does not make its facilities available to any special-interest groups.

12. The Montgomery County Medical Society has protested Faculty approval of the Blue Shield Prevailing Fee Program. The Society is to be advised that the Council did not approve this program. It is to be further advised that the Montgomery County representative on the Council has attended only two meetings in three years. If the Society wishes to replace their Council representative they should request the resignation of the incumbent. Finally, the Society is to be advised that the survey is being done by Blue Shield, not by the Faculty.

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The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

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2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

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The Vise of Alcohol

JOHN O. NEUSTADT, MD†

WHEN I WAS TRYING to reconstruct the planning that went into setting up this panel by Dr. Vernon Smith and his committee with its special attention on medical vice ("Medical Aspects of Vice" is what the program says), the order of panelists interested me. Here we were all assigned a half hour to cover these aspects in this fashion, and I wondered why the order was originally gambling and the girls, then smoking, then drinking. I don't know what change led to placing the discussion of smoking first, whether that indicates an increasing or decreasing order of importance. In any case, I came to the conclusion that the order had been decided on by this principle: that after an evening at cards with the girls in a smoke-filled room, or even more so in a smoke-emptied room, there's nothing to take the place of a good stiff drink.

This interpretation of the order of the speakers at this meeting was presented by me to the former dean of the Johns Hopkins University School of Medicine, his successor, and several other of the senior medical men in that institution at lunch yesterday. They disagreed with me. Led by the present dean, they concluded instead that the unmistakable purpose of the planners of this panel was to provide this audience with this knowledge: prostitutes should never gamble with smoking in bed while drunk.

You may agree with me that it is strange the activities that have been listed here tonight as vices: smoking, drinking, gambling, and sex. I suppose we should be thankful that so far nobody in medical research has turned up indisputable indications that breathing, neither breathing in nor breathing out, is especially dangerous. Actually, it *is* somewhat dangerous if carried to extremes and can become so severe a habit as to be called a vice. It might then be labeled "air-greed," or, put in scientific German, "Luft-Lust."

Certainly those of us who have worked with patients in hospitals have seen them become addicted to having their breathing done for them, as for instance patients in a respirator, after their recovery from poliomyelitis and other illnesses. The difficult problem is to wean them from the respirator. That's how everyone on the ward talks about it—as a weaning process.

Now there's another breathing assistance that has come into vogue in recent years, thanks largely to the efforts of Dr. Peter Safar, who was at the Baltimore City Hospitals for many years; this is called "mouth-to-mouth breathing." I understand that it has become extremely popular among young people on the beaches in the evening; hence it, too, could become an addiction or a vice.

Without question vices relating to alcohol merit our attention. And there are *some* vices that are surely connected with alcohol. There is, for example, a sense of willful choosing of possible harm that sets the stage for what we call alcoholism.

Nonetheless, it is well that we not overlook the virtues that go along with these vices. Let me quote for your pleasure from the incomparable Dr. William Dock's remarks. Dr. Dock is from New

Presented May 7, 1964, at the annual meeting of the Medical and Chirurgical Faculty of the State of Maryland. This paper was part of a panel on "Medical Aspects of Vice."

†Dr. Neustadt died November 19, 1964. He was assistant professor of psychiatry and instructor in medicine, The Johns Hopkins University School of Medicine.

York City, and he attended a symposium on alcohol in that absolutely appropriate state of California in 1961, where he said we need

> Proper perspective about alcohol in an age and land where the therapeutic and civilizing functions of alcohol are concealed by its abuse among those crippled in the urban rat-race. . . . We seem now to have a nihilistic attitude toward a chemical which is a proved diuretic, a stimulant of gastric secretion, a dilator of blood vessels; and which, above all, has an action on the mind which by varying the dose and the rate of ingestion can bring either cheerful bustle or profound anesthesia.[1]

Dr. Dock went on to say,

> Alcohol, as the human race discovered thousands of years ago, makes one's troubles whether organic or emotional seem less alarming. This carefree attitude, so dangerous for the automobile driver, is most helpful for the aging parents of normally ungrateful children (and there is the genius of Dr. Dock, that word "normally"), as well as for the man or woman with failing sense organs or failing vital organs, with dying contemporaries and a narrowing circle of friends.

Dr. Dock was obviously feeling his age but, as always, quite illuminatingly for the rest of us. There are a few other quotations from that same symposium that you might enjoy. Jules Masserman:

> Addiction to drink, then, is a "disease" only in the sense that excessive smoking, gambling, or wandering are also "dis-eases"; that is, partly condoned ways in which men try to haze over, compensate for, challenge, or escape from . . . un-ease.

Also Chauncey Leake:

> The use of alcoholic drinks at the end of an emotionally gruelling day may have a real civilizing effect on the over-tense, over-wrought, over-anxious, and over-irritable *husband* (that's the only noun in his comment so far) seeking rest and peace in his home. . . . A couple of cocktails . . . will really perform wonders in helping husband and *wife* (now the other noun comes in) to feel tolerant and understanding of each other.

Finally, Leon Greenberg summarized it: Alcohol used in moderation is, I believe, of all the tranquilizers, probably by far the oldest and probably, for most people, by far the safest"; and Dr. Dock suggested that anyone who invented alcohol yesterday would be a billionaire today.

But it is obvious that we are here to talk about alcohol not just in these socially useful, graceful, and amusing ways but about its abuses. In this connection, perhaps many of you are aware of the medical legend that says that all doctors suffer from their own diseases: for instance, all neurologists and neurosurgeons have migraine. The legend gets a little shaky when you talk about male obstetricians and gynecologists, but I have been thinking, in preparation for this panel, that this legend puts Dr. Hochbaum in a rather compromising position, me in a somewhat worse position, perhaps; but I am not sure that I don't envy Dr. Linden.

Fig 1

DEFINITIONS OF ALCOHOLISM

I. Chronic behavioral disorder:
- **1. detrimental preoccupation,**
- **2. loss of control,**
- **3. self-destructive attitudes;**

resulting from:
- **a. early deprivation and altered physicochemical responses,**
- **b. significant identification with excessive alcohol users,**
- **c. milieu causing ambivalence, conflict and guilt.**

(Chafetz & Demone, *Alcoholism & Society, 1962.*)

II. "Any use of alcoholic beverages that causes any damage to the individual or society or both."

(Jellinek, *The Disease Concept of Alcoholism, 1960.*)

Definitions of alcoholism, adapted and quoted from two recent texts.

Alcohol and alcoholism are so familiar to so many of us that, like all such things, it is curiously difficult to see them. They're so close we can't even make out their features. It's like our friends, our family, the paintings in the room, we so often don't realize what is present until we conscientiously set out to take account.

Let me show you what alcoholism is like as a field of study and how, for instance, two serious and important investigators can diverge apparently when trying to frame the essence of what they are talking about. Figure 1 is taken from two of the best recent books.

Alcoholism is a "chronic behavioral disorder" signaled by a "detrimental preoccupation" with alcohol, which means a continually increasing and damaging obsession. "Loss of control" means that once the drink is taken, a person of this description is not able to stop. Dr. Tuerk tells about a man who knew that he should never take the *first* drink; so he learned to go into a bar and ask the bartender for a drink, which he then set aside, in order to begin with the second. "Self-destructive attitudes" are exemplified not only in these alco-

Fig 2

ALPHA ALCOHOLISM

("Problem Drinking")

1. **Psychological reliance: relief of felt pain.**
2. **"Undisciplined" rule-breaking: time, place, event, amount, effect.**
3. **Damage: Interpersonal Family Budget Some absenteeism production loss nutritional deficiencies.**
4. **NO Loss of Control Inability to Abstain Withdrawal Effects Signs of Progressive Process.**
   (Yet, may be developmental stage.)
5. **Symptom of pathology it relieves.**

"Alpha alcoholism," one of the species defined by Jellinek, as adapted from *The Disease Concept of Alcoholism*.

holic involvements but in other matters as well.[2]

The "resulting from . . ." portions of the definition represent efforts to bring together a wealth of material, some of it speculative, some of it illuminating, and some biochemical. For instance, the "early deprivation and altered physicochemical responses" implies that there is a biochemical parallel to the emotional life.

"Significant identification with excessive alcohol users" means early intimacy with repeated drunkenness, maybe in good old Uncle Charlie whom he really loves. The "milieu causing ambivalence, conflict and guilt" refers to many other issues in addition to alcohol.

The second the bare-bones definition of Jellinek.[3] Let me read you what Jellinek said in defense of this definition. "Vague as this statement is, it approaches an operational definition," and as a weary investigator in the field of alcoholism, I can assure you he's right. Jellinek goes on:

> It may be said that such a loose definition has little value. With such a vague definition, we cannot even ask whether alcoholism so defined is an illness. Obviously, there are species of alcoholism—so defined—which cannot be regarded as illnesses. One may well say that such a vague definition is therefore useless. But in this uselessness lies its utility, for it forces us to single out species of alcoholism . . . and to speak of them in stringent terms. We must be particularly definite about those forms which we wish to examine as possibly constituting illnesses."

Jellinek went on to spell out what he means by the various species of alcoholism, particularly those he proposes be accepted as illnesses. These were covered recently by Dr. Marvin Block when he spoke before the City Medical Society. I've tried to compress and put them together for this occasion.

Figure 2 illustrates what Jellinek calls "Alpha alcoholism," which means the way so many people you know drink, but it doesn't necessarily become an illness. "Problem drinking," psychological dependence, undisciplined, these are the people who drink too much in the wrong places. It can damage interpersonal life, family budget, and work but without any loss of control or the inability to abstain; with no withdrawal effects nor progression. Yet, it may be a developmental stage, when reviewed years later. The final statement is very nice, the usual paradox that is so often useful: a symptom of the very pathology that it relieves. Excessive drinking relieves something, and what it relieves it is also a symptom of.

The Alpha is a whiskey drinker, and may well be called an alcoholic in America; but Beta alcoholism (Fig. 3) is the wine-drinking, French-type alcoholism, and I've called it here "insidious imbibition." Beta alcoholism results partly from the social pressures of the community that conspire to make people drink frequently and, combined with poor nutrition, produces most of the common diseases we know that go along with alcoholism. Jellinek says "no interpersonal damage," but I have added that question mark; I find it difficult to believe. No withdrawal effects and no dependence—these people just drink incessantly, by his account.

Fig 3

BETA ALCOHOLISM

("Insidious Imbibition")

1. **Social habituation & pressures: custom, culture, economics.**
2. **Poor nutrition and physical damage: cirrhosis, gastritis, polyneuropathy; nutritional deficiency diseases.**
3. **Damage: family budget, production loss, curtailed life span.**
4. **NO Interpersonal (?) Withdrawal Effects Dependence, psychological or physiological.**
   (Yet, may be developmental stage.)

"Beta alcoholism," another species defined by Jellinek, adapted.

Fig 4

GAMMA ALCOHOLISM
(AA Image)

1. **Physical dependence ("craving") and withdrawal effects.**
2. **Acquired increased tissue tolerance and adaptive cell metabolism.**
3. **Loss of control.**
4. **Damage: Greatest, in all spheres.**

DELTA ALCOHOLISM
("Inveterate Drinker")

As above but,

3: **Inability to abstain (vs loss of control).**

"Gamma" and "Delta" alcoholism, adapted from Jellinek.

Gamma alcoholism (Fig. 4) is the one that interests Jellinek the most. He considers AA influential in having made it regarded as the only type of alcoholism where there is true physical dependence—what they call "craving"—and a real withdrawal syndrome. And then these terms "tissue tolerance" and "adaptive metabolism" I won't bother to define for you now, but they mean that something has changed in the central nervous system. *Loss of control* is the principal manifestation; one drink and that's it, although these drinkers can often abstain between bouts. Damage is great in all the spheres mentioned.

Delta alcoholism (Fig. 4) is the equivalent French version of going over the boundary into true addiction; this is the inveterate drinker. All these things are the same except he cannot abstain like the American whiskey-drinker. He drinks his three liters of wine every day, every single day, but he doesn't "lose control."

Figure 5 shows some of the other species Jellinek mentions, added to a little by me. "Alcoolisation" is a French term; you certainly know what "drunken driving" is; and "periodic dypsomaniac," the fellow who stays dry for six months and then goes on a prolonged spree. "Explosive drinking" occurs when a man takes just a few drinks and then becomes really psychotic; "fiesta drinking," like people who go to New Orleans in February; "lost weekending"—you know as many of these as I do. Perhaps the chief merit of Jellinek's scheme, as he himself comments, is that his use of the Greek alphabet allows for numerous species to be added.

Fig 5

OTHER ALCOHOLISM SPECIES
(α-ω)

"Alcoolisation"	**Explosive Drinking**
Drunken Driving	**"Fiesta" Drinking**
Epsilon: "Periodic Dipsomania"	**Lost Weekending**
	You Name It.

Other species of alcoholism, adapted from Jellinek.

The incidence of alcoholism is the next issue to consider. It's difficult to estimate the statistical impact, and the reason is obvious. People just don't run down to the health department and check in to tell them, "I'm now an alcoholic, not a gambler, nor a prostitute, and so forth." An indirect method is necessary to get some idea of the magnitude of the incidence.

Fig 6

JELLINEK ESTIMATION FORMULA (1940)

$$\text{"Ailing" Alcoholics} = A' = \frac{D\,P}{C_1 C_2} \times 100 = \frac{D\,P}{K}$$

where A′: Ailing alcoholics alive in a given year,
D: # reported deaths from cirrhosis that year,
P: % D attributable to alcoholism,
C_1: % Ailing alcoholics with cirrhosis,
C_2: % C_1 dying from cirrhosis.
K: $\frac{C_1 C_2}{100}$.

Then, Total Alcoholics = A = R A′,
where A: all alcoholics alive in a given year,
and R: ratio of all alcoholics to all ailing alcoholics.

The Jellinek formula for the indirect estimation of the incidence of alcoholism, based on observable incidences of cirrhosis; and adapted from Jellinek.

Jellinek devised this formula (Fig 6) to obtain some rough approximation of the impact of alcoholism, as derived from observable medical facts.[4] The formula depends on taking the observable facts, like the number of deaths reported annually from cirrhosis (D in the formula) and the findings of cirrhosis in alcoholics, whether incidental (C_1) or fatal (C_2). These determinable facts also permit an immediate estimation of one other factor: how many of the deaths from cirrhosis were related to alcoholism (P). This can be determined by history and examination.

Fig 7

ALCOHOLISM INCIDENCE: 1960

	Total	Men	Women	Men:Women	Rate (DAP)	Rank
1. USA (10^6)	4.5-6.4	3.8	.7	5.4	4%	
2. Maryland (10^3)	73.8-105.5	64.5	9.3	7.0	4%	17
3. Nevada (10^3)	11.7	10.3	1.4	7.4	11%	1
4. Alabama (10^3)	32.7	26.4	6.3	4.2	2%	48

The incidence of alcoholism in the United States and selected states in 1960, as estimated by Efron and Keller, using a modification of the Jellinek formula; with supplemental estimates by Gibbs.

All of these factors go together in this way to give you a figure that stands for "Ailing Alcoholics," which is my brief term for what is called "alcoholics with complications." Taking that number, and using an estimated ratio of four or five to one (the ratio obviously varies in different places at different times), you can find out how many alcoholics there are altogether by the Jellinek formula. So far, this is the only standard way of making reasonably valid estimates of alcoholics in a given area.

Reviewing all this, I wondered if maybe in some circles a more direct method of estimation might not be to count the number of guests still going strong at a cocktail party three hours after it was supposed to be over and multiplying by the number of olives left in the martini glasses.

Figure 7 gives some statistics reached by application of the Jellinek formula. The 1960 alcoholism incidence for the USA as worked out from that formula (modified) was 4.5 million.[5] Dixon Gibbs questioned the validity of this estimate and went back over the figures and the original formula. He got the estimate of 6.4 million, and I think he's right.[6] But, using the 4.5 million figure as given by Efron and Keller, here's how it divides between men and women: 3.8 million men and 700,000 women. The ratio is 5.4:1. Perhaps the most significant way of looking at these totals is this figure of 4% in the column marked *Rate*. The *DAP* abbreviation stands for the *Drinking Age Population*, which is everyone in the United States over the age of 19. In effect, this states the important comparison of actual alcoholics as compared with all those who might be considered to be at risk of alcoholism.

The next figures are for Maryland and are in the thousands, ranging from 74 to 105 in Keller's[5] and Gibbs'[6] estimates. You notice that the ratio of men to women in Maryland is higher than the national average, whatever that means. You also notice that we rank seventeenth in the states and with a rate exactly the same as for the entire country.

Nevada has the highest incidence of alcoholism, and here you see the number of men and women. The ratio of men to women is even higher than the national average; hence the likelihood that the problems brought to Reno contribute to these figures just doesn't seem to show.

Alabama has the lowest incidence, and the ratio of men to women drops way down. My conclusion is that the gallant southern woman wants to save her man from danger and to make the ultimate sacrifice by sharing his condition.

My professional interest in the incidence of alcoholism dates back more than 10 years because of my connection with the Baltimore City Hospitals, where alcoholism matters tremendously much. One day in November, 1960, four assistant residents who were running the four medical wards estimated for me the impact of alcoholism in all medical patients present on the wards for all medical reasons. In order not to influence them with my bias, I asked them to do the rating without consulting with me or anyone else. I asked them to consider that "non-alcoholic" means that the patient either doesn't drink or doesn't drink any more than they do or doesn't drink enough to be a problem as far as they can tell. If they think he is an alcoholic, please rate him as doctors do everything, on a scale of 1 to 4 plus.

Figure 8 shows the results of that study. These are all acute medical patients. There were 67 on the ward at the time. (We did not include polio patients, who were from a different socioeconomic

Fig 8

ALCOHOLIC SURVEY: BCH 1960

	Men	Women	Total
1. All acute medical patients	34	33	67
2. Obvious drinking problems	20	6	26
3. Percentages	59%	18%	39%

Alcoholism among all patients on the acute medical wards of the Baltimore City Hospitals on November 29, 1960, as estimated by the four assistant residents in medicine in charge of the wards. (Poliomyelitis patients omitted; also admissions and discharges of that day.)

Fig 9

ALCOHOLIC SURVEY: BCH 1964

	Men	Women	Total
1. All acute medical patients	43	22	65
2. Obvious drinking problems	31	8	39
3. Percentages	72%	36%	60%

Alcoholism among all patients on the acute medical wards of the Baltimore City Hospitals on April 30, 1964, as estimated by the six assistant residents in medicine in charge of the wards.

Fig 10

ALCOHOLIC SURVEY: JHH 1964

	Men	Women	Total
1. All acute ward medical patients	62	57	109
2. Obvious drinking problems	27	10	37
3. Percentages	44%	18%	34%

Alcoholism among all patients on the acute medical wards of the Johns Hopkins Hospital on May 1, 1964, as estimated by the nine assistant residents in medicine in charge of the public wards.

class, nor patients admitted or discharged that day, whose charts were not in the office.) The number of men and women was about the same, meaning men and women on the wards for everything from heart attack to arthritis to whatever. The incidence of alcoholism among male patients was estimated by these assistant residents (and their separate estimates compare reasonably well) as roughly 60%; and among women as roughly 20%; for a net 40%.

Negro and white patients were approximately equal in number so that racial factors seemed irrelevant. Particularly important was the fact that most of the alcoholics in these estimates were in the mild-moderate categories, which means potentially redeemable. The more severe alcoholics were all hospitalized for illnesses directly related to alcohol.

My wife pointed out that a one-day sample might not be very convincing. It could be slanted, or just happen to be true that day or that season, and might be different on another occasion. So I repeated the survey last week (Fig 9). This time there were 65 patients on the ward, and the estimates of alcoholism were 72% among the men; 36% among the women; with a 60% overall. I don't quite believe these figures, and my guess is that the residents were not as fully instructed as the time before. I am not at BCH full time now, and I will have to go back over these figures with the assistant residents because I think some of them put too many patients down as alcoholics. In any case, it shows at least that there is no improvement in the four years since we did the first survey and that the figures are no better.

Then I thought perhaps all this might be viewed as something special in the City Hospitals' population. So the next day I went on the public medical wards at Johns Hopkins and did the same thing (Fig 10). Here we have 109 patients in all, and approximately the same number of men and women; and the reported alcoholism was 44% of the men; 18% of the women; for a 34% average overall. I also don't believe these figures entirely either, but for the opposite reason. There were some assistant residents who were too conservative, as their chief resident had warned me might be true. Certainly when two residents are on the same floor, dividing up the care of patients evenly, when one of them reports no alcoholics and the other reports four or five, it doesn't seem entirely likely. In any case, these figures from the 1964 studies at both City and at Hopkins have not been worked over with the same intensity and careful review as the 1960 study. But they do give at least a consistent idea of the magnitude of the problem.

There are many important theories, hypotheses, and apparent factors connected with how alcoholism starts. I am not going to try to cover them all but rather to focus on one or two. Psycho-

analysis, with theories of orality and so forth as discussed by Dr. Linden, provided initially exciting ideas and more recent investigations have been turning up some new considerations. I thought you might be interested to learn about these newer approaches, since the older notions have been such common coin throughout the many years since Freud's discoveries.

It was once associated with Dr. Lester Gliedman, at Hopkins, who was productively struck by the clear fact that so many alcoholics have a tremendously constricted time-sense. They just seem to be aware only of the present. Indeed, he called this "present-orientation"; and the attitude it represents could well be characterized as impatience. Similarly, the inattention to the past, you might refer to as impulsivity; and the corresponding inattention to the future, heedlessness. These three characteristics of impatience, impulsivity, and heedlessness are indeed striking.

Then, Dr. Gliedman became fascinated with the many intriguing parallels between alcoholism and another condition in which these three characteristics are often seen so clearly: brain damage. He began some studies that we, his colleagues, have carried on to explore the interplay between heavy drinking and early brain damage, as well as personality factors. We believe we have found significant differences in the conditionability and arousal patterns for alcoholics as opposed to controls, matched in all other regards, which may shed some light on this interplay.

The most promising line of investigation today deals directly with the most critical issue in alcoholism. Lots of factors have been considered: psychological, physiological, sociological, and other possibly fruitful approaches to understanding alcoholism. But the critical center is when and how this escape route, this habit, this dependence, becomes an addiction with all the properties of any addiction that we know anything about—morphine addiction, cigarette addiction, any other. The best work that I know on this central problem has been done by Dr. Robert Myers, who used to be at Hopkins and is now at Colgate, and I would like to sketch it for you briefly (Fig 11). He put little tubes into the brain ventricles of rats to avoid the problem of absorption, of crossing the blood-brain barrier, and so forth. These charts simply show that the rats that got high concentrations of alcohol steadily in their brains developed a fantastic taste for drinking the most fantastic quantities of alcohol, up to 30% concentration; this was a breed of rat that normally drinks no more than 5% or 6% in water. In the experiment, the control rats amiably sipped alcohol in concentrations of 3% most of the time, but they balked as the beverage concentrations were increased and went completely on the water wagon as the alcohol concentration approached 10%. But the rats infused cerebrally with the highest amounts of alcohol kept slugging away the drinking alcohol almost exclusively until the beverage concentration passed 30%![7]

Figure 12 is another chart from the same paper by Myers,[7] which records an even more striking observation that is as profoundly important as any yet in the literature. Here, alcohol in microliter amounts was put into the brains of rats for five days and then was stopped. But even after the brain infusion was stopped, the rats went along preferring to drink alcohol in concentrations up to 15% as against water. Then for five days the rats were given nothing to drink but water. Then they were offered alcohol again, and again they preferred it to water in the 10%-15% range of concentration. Tranquilizing drugs for the next few days had slight effect, except perhaps to whet the rats' taste for more alcohol. (These were rats with no previous experience with alcohol, of a breed that normally will not drink greater than a 6% alcohol concentration.)

I would like to say a few serious words about what it means to be an alcoholic. It does not seem likely to me that hell is any the less hell because it was built drink by drink by the inhabitant nor because it exists now just as well as hereafter or can be found night after night as well as in eternity. There are those who can and those who do drink sociably and enjoyably as part of the celebration of home and family, of friends and warmth, those who drink in time-honored associations and even in celebration of God's goodness and His gifts. But there are those, many of them better men than I, for whom that same warm cup that cheers and delights or makes tender and vivid becomes the avenue to degradation, self-hate, and destruction of themselves and everything they love. Some of the best brains ever fashioned finally procured their own destruction, or near destruction, by taking enough alcohol to turn that often friendly substance into a poison that no brain, no matter how wonderful, can forever withstand.

I had the extraordinary fortune to know only

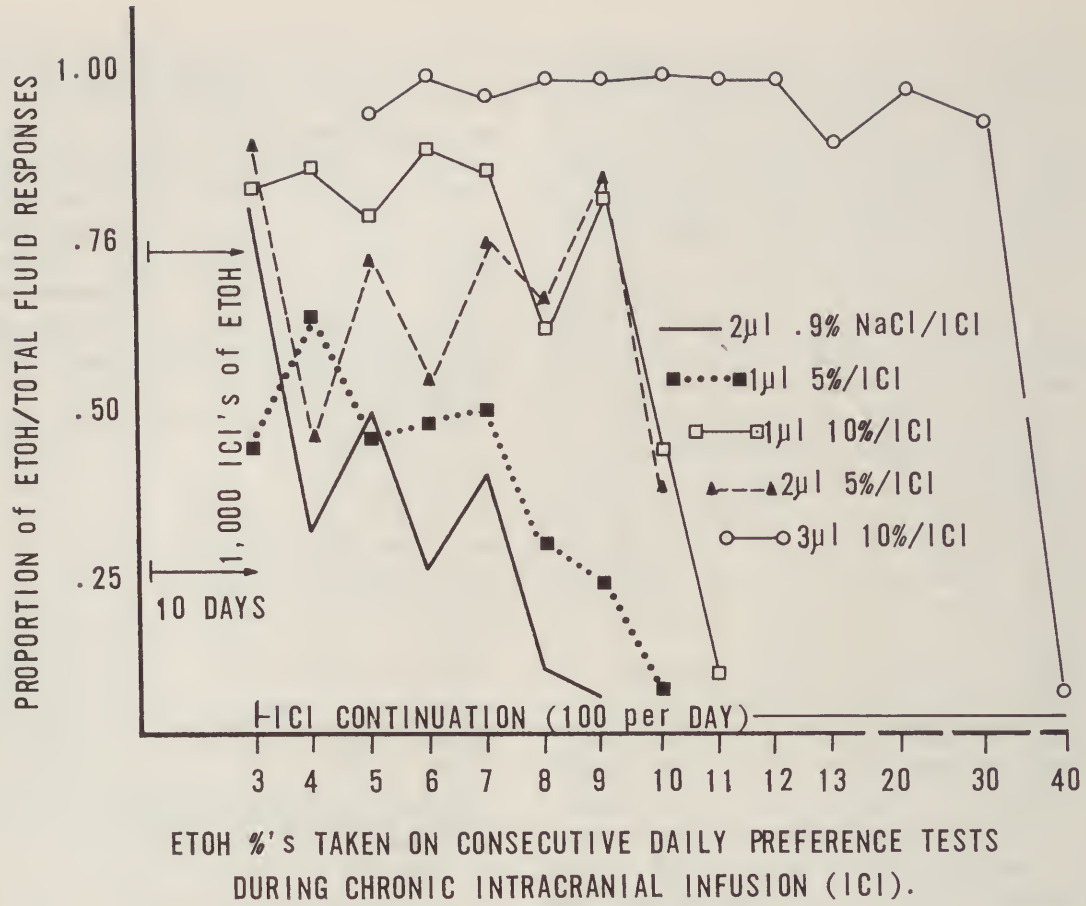


Fig 11

Preference for drinking high concentrations of alcohol (as opposed to water) in rats infused intracerebrally with high concentrations of alcohol, as compared to control rats infused with saline and lower concentrations of alcohol.[7]

slightly, but unforgettably, when I was 17 or 18, one of those glorious brains that some of you here tonight may have known better than I. It belonged to F. Scott Fitzgerald, and I am sure that is one reason that I am standing here on this panel tonight in this role.

There are other once beautiful persons whose names are familiar to you all that I could mention, but perhaps we would do better instead to call that roll together in silence and in prayer. And let me remind you that in some eyes, namely their children's, those BCH patients I counted for you aren't just statistics, but every bit as dear, as crucial, and as determining to those children as the finest and noblest names I could have mentioned a moment ago.

I bring this all up in this way because this is the way that people like myself feel who work away at this problem. The problem is, of course, infinitely more complex and monstrous than our few poor tools to deal with it. And there are those who scoff at efforts by hospitals, doctors, and many specialists, not just psychiatrists, in fact not even particularly psychiatrists, but various doctors, psychologists, social workers, clergymen, nurses, and all the honorable roll. Some people scoff at all that. They scoff at the official stand of the AMA that categorizes alcoholism as an illness and hospitalisable. They think that the attempt to find a formula for making alcoholism a matter of serious, responsible, scientific, and helpful concern is simply nonsense. These are the people who say, "It's a weakness," "It's a self-indulgence," "It's a deliberate willing of evil versus

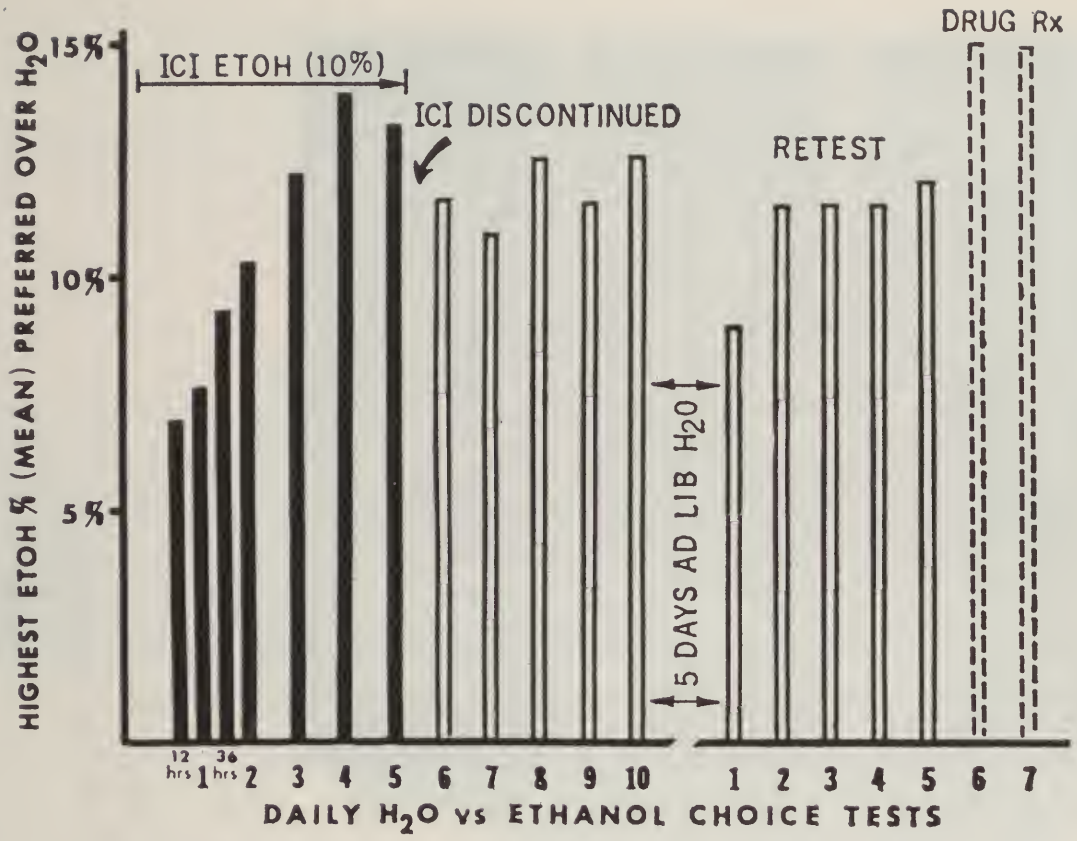


Fig 12

Continued preference for drinking high concentration of alcohol in rats previously infused with alcohol intracerebrally, after the cessation of infusions; and resuming after a five-day total unavailability of alcohol. Tranquilizing drugs (meprobamate and hydroxyphenamate) only increased the oral intake of alcohol.[7]

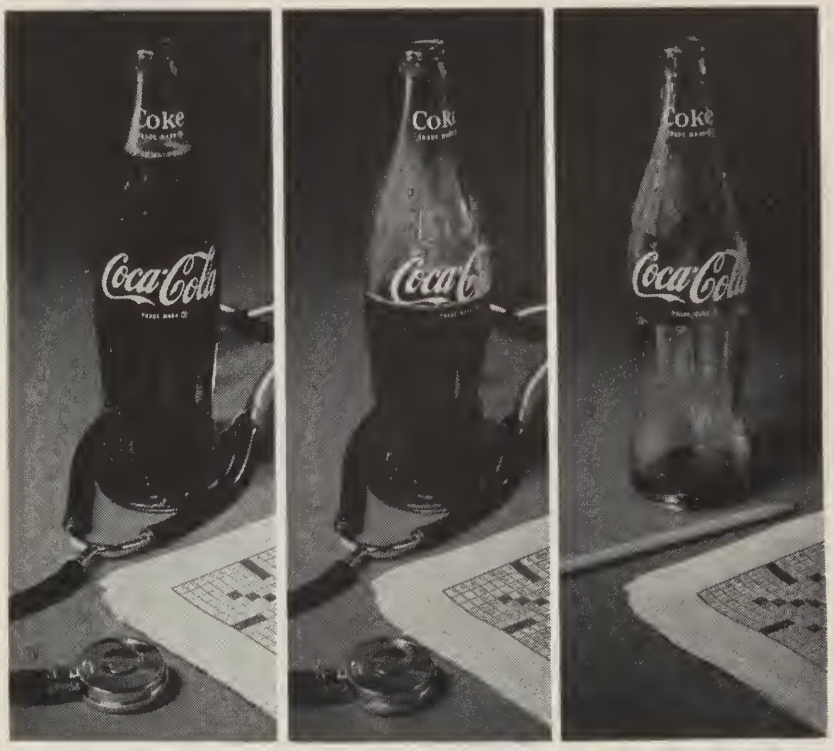
good"; in other words, a sin, or in the words of the panel tonight, a vice.

Well, it is an intricate matter for me, as it must be for you, to separate out free will from necessity. It always is, and that issue has occupied the minds of many thoughtful men through centuries. But we are doctors, we are physicians, we come from a tradition that didn't ask for the philosophical definition and the moral categorization of suffering before trying to relieve it. Doctors through the ages didn't wait till all the scientific evidence was in, the irrefutable pathophysiology and the infallible remedies, before trying to do something for people suffering from mysterious maladies (and of course all maladies are mysterious, as indeed the absence of malady is).

In our tradition in medicine is a staff with a snake entwined that goes back to Asclepius. I tried to find out whether that snake had a traditional name and what it might be. I couldn't, but I have a notion of what that name should stand for. It is skilled, compassionate responsibility, applied wherever it can be of use and benefit.

Think of our predecessors down the centuries who didn't know that appendicitis existed. They didn't know about myocardial infarction; schizophrenia, ACTH, or desoxyribonucleic acid. They didn't have all our modern advantages: the x-ray, the research lab, the Hill-Burton Act, and the antibiotic, the computer and the administrator, Ben Casey, *Time*, and the *Reader's Digest*. Well, what did they have? Just what we would have if those modern miracles were taken away from us: that staff and that snake. That skill as good as we and our schools can make it. That compassion, the best we self-invested creatures can give. And that responsibility that permits us as trusted, trained, and licensed agents of society to share or take for the patient—and equally for his family—the grave significant troubles and decisions that he and they face.

Those three things: skill, compassion, and re-



11:47 pm 11:53 pm 12:06 am

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sponsibility are what every man needs and asks of us in the hour of his death; yea, and even in the meaningful crises of his life. And if we offer not some portion of these qualities, we be as tinkling symbols.

The scoffers point out what we already know only too painfully: that we doctors can't really quite know what we are doing. But, by God, we do it.

Doctors have always taken account first of the need that we could recognize and then of the amelioration that we might bring. And amelioration is the act that we better become fond of now that "cure" has been lost to us in almost every branch of medicine. So we take account of the need and the amelioration before turning to acknowledge the enormity of our ignorance; and then we—or at least the talented ones of us—turn to relieving that ignorance, just as the rest of us try to relieve the patient.

We go about our work, I hope and I believe, as quietly, as sturdily, and as sensitively as we know how, giving our diuretics, our antibiotics, our tranquilizers; without shrinking, without apologizing, and without insisting on sifting out definitively the moral and ethical aspects of the patient's illness beforehand, when our job is to *care* for him.

I wanted to talk about the vise of alcohol, V-I-S-E. I wanted to ask those who came tonight to join in the search for ways to get back out of that vise all those we can who are now caught in its relentless jaws. And to do it just as urgently and thoughtfully as those do who are exploring for us how those jaws ever closed.

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ECONOMY

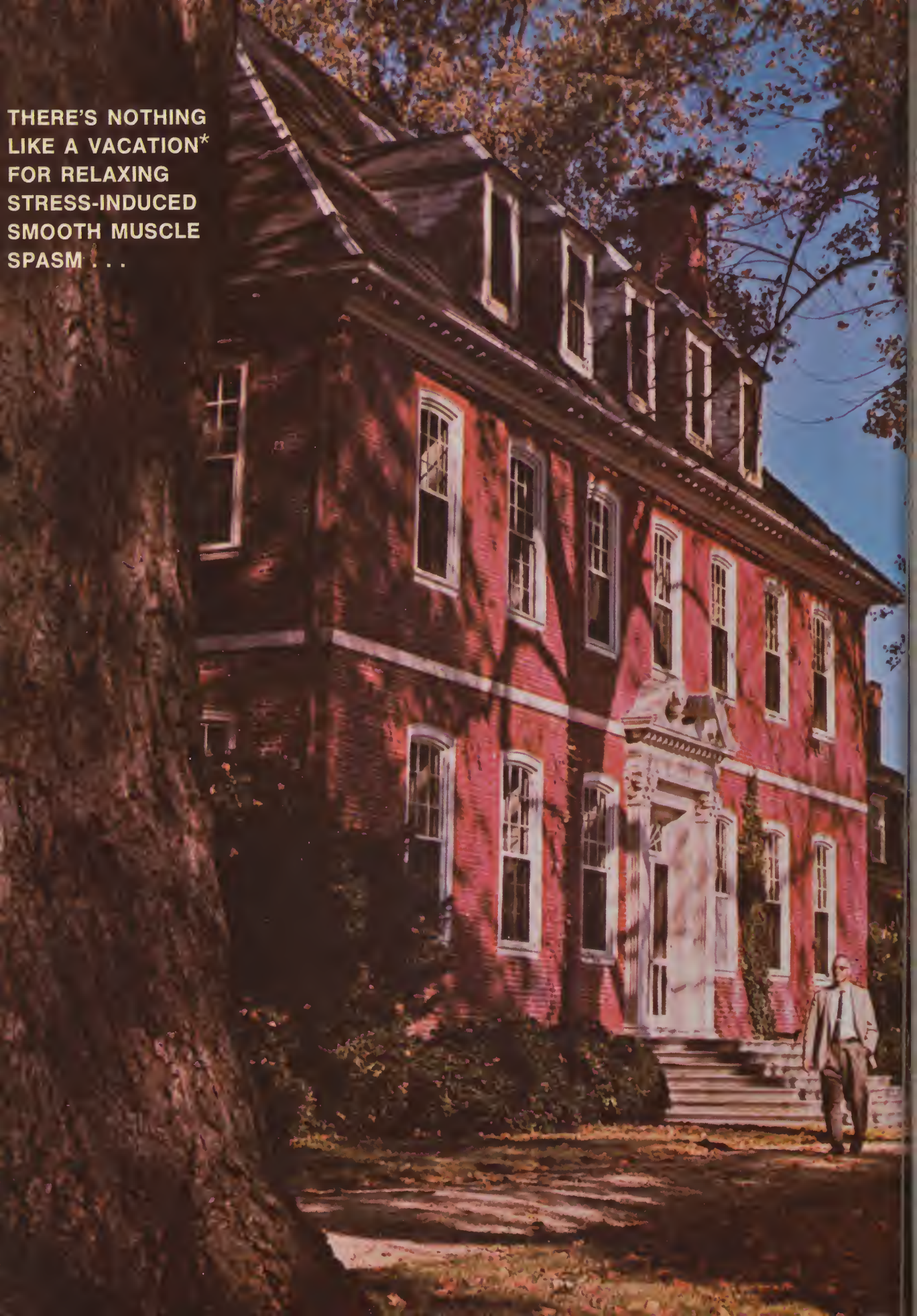
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Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

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Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

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BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

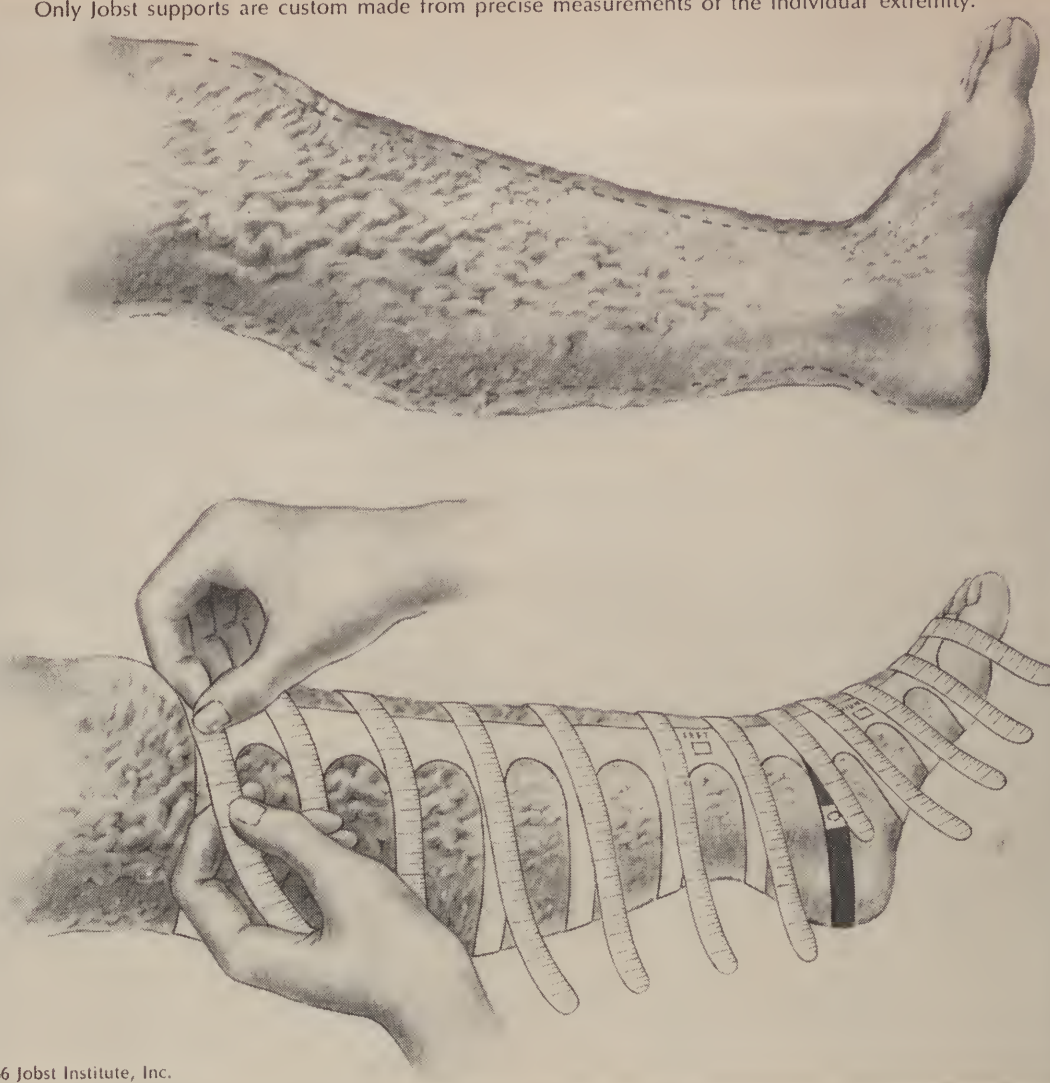
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*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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GLAUCOMA PATIENTS / A Plan for Improved Management

A central glaucoma testing facility staffed by technicians under the direction of a board of ophthalmologists would facilitate the testing and retesting necessary for proper management of glaucoma patients.

DAVID PATON, MD

The ultimate aim of all investigations of glaucoma, whether clinical or research, must be the improved care of the patient. But little attention is now being given to the practical problem of how every patient with glaucoma can receive the careful, professional scrutiny his disease requires.

As the population enlarges and ages, the prevalence of glaucoma is constantly increasing. There are approximately one million citizens in the United States with glaucoma. Of the quarter of a million persons who are legally blind, about one-fifth have glaucoma. Unquestionably, glaucoma is the most significant cause of blindness in this country; yet a relatively small number of physicians must manage the hordes of patients with this disease.

According to statistics from the American Board of Ophthalmology, there are about 4,600 Diplomates practicing in the United States. Approximately 3,000 non-certified ophthalmologists, or EENT physicians, have clinical practice; and the American Medical Association reports that there were less than 1,000 residents in ophthalmology as of 1962. If all of these physicians are grouped together—the only people qualified to manage glaucoma patients—conservative estimates show that there are between 100 and 200 glaucoma patients to be cared for by each doctor. This number has particular importance when it is realized that glaucoma, like diabetes and heart disease, is a chronic ailment whose course and control must be precisely monitored.

Practical measures for improving management of our country's glaucoma population have not kept pace with present-day knowledge of how blindness from glaucoma can be checked. We know that every patient's intraocular tension should be constantly maintained at normal levels. We know that every patient's visual field must be diligently tested and retested to assure adequacy of tension control. If the patient is not followed closely, with rigorous attention to both intraocular tension and visual field changes, the physician is compromising what he knows to be optimal glaucoma management. The treatment of each patient, whether medical or surgical, must be custom-designed. There is nothing to indicate that glaucoma can ever be managed by predetermined formulas.

Thus, the typical ophthalmologist is confronted by a time-consuming responsibility for his glaucoma patients; yet these cases usually constitute a minor portion of his total practice. Patients with glaucoma may have to wait several months for a routine checkup because the doctor is heavily scheduled in advance. Even then, retesting may be limited to a single tonometer reading and perimetry—inadequate information to assure optimal control.

There are other difficulties, too, in the usual office management of a glaucoma case: visual field charts of one physician are often of no value to a consultant because different testing techniques prevent accurate interpretations. Certain surgeons may staunchly advocate a given operative tech-

From the Wilmer Ophthalmological Institute, Baltimore. This paper was read at the Glaucoma Symposium of the Manhattan Eye, Ear and Throat Hospital and the New York Association for the Blind, May 16, 1964.

nique without being able to appraise their results objectively in relation to others, because there are no standard criteria for comparisons. The major factors in glaucoma care are the ophthalmologist's time, his particular interests, and the availability and competence of assisting personnel to expedite his studies.

There seems to be no adequate means of assuring optimal nationwide glaucoma management if all the testing and retesting of glaucoma patients is performed exclusively by ophthalmologists. In my opinion, the crux of the problem is the extent to which ophthalmologists are willing and permitted to rely overtly upon technical assistants in performing tonometry, tonography, and perimetry.

In medical teaching centers and ophthalmology departments of various sizes, most testing is performed by technicians under the direction of ophthalmologists. Because of priority clinical-research projects and inconvenient locations of the testing facilities, the services of these technical staffs are generally not suited for large-scale work with routine patients; and even if they were, such services might not be available to patients of ophthalmologists unaffiliated with the parent institution.

Some ophthalmologists employ their own technicians, often a privately instructed nurse; but because of other office duties and the limitation of time available for glaucoma-testing alone, the patient management can be very haphazard when it is not performed according to systematized technique by full-time technical workers. Compromise in obtaining complete re-evaluations is too often an undesirable necessity.

I have been interested in the continuum of glaucoma management. In early 1960, a proposal to establish a community glaucoma facility for the use of practicing ophthalmologists was drawn up and submitted to the Eye Section of the Baltimore City Medical Society. It was hoped that this "testing station" for patients with glaucoma would be a prototype for future affiliated facilities throughout the country, so that uniform standards of technician training and of testing methods could be maintained. The Baltimore facility was to consist of a suite of rooms in a medical office building, near a teaching hospital but completely independent of that hospital. It was to be a nonprofit organization under the direction and supervision of a board of ophthalmologists. The purposes of this trial facility were to be: 1) to obtain a practical method of providing ophthalmologists with complete technical information on the adequacy of tension control in their own patients; and 2) by compiling objective data, to determine optimal methods of medical and surgical control of glaucoma.

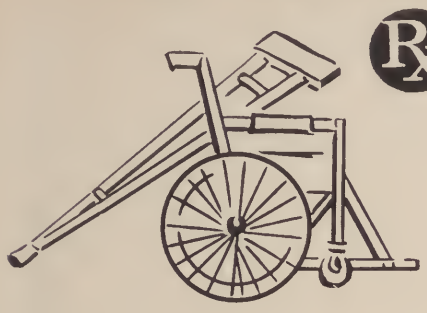
According to the plan, the ophthalmologist would send his glaucoma patient to the facility with a card containing basic information for filing, such as the patient's diagnosis, history of ocular surgery, and current medications. At the facility, trained technicians would perform measurements of visual acuity, visual field testing with standardized targets and stimulus intensity, and tonography, with or without a water provocative test, depending upon the request of the ophthalmologist. Originally it was suggested that the facility be prepared to measure diurnal tension variations, but this eventually seemed impractical outside a hospital environment.

The estimated cost to the patient (and indirectly to the doctor) for the technical services of this large-scale glaucoma testing station would be considerably less than if this work were done in a doctor's private office. The availability of the service to every patient with suspected or definite glaucoma would, of necessity, improve the quality of glaucoma care available to the community without detracting from the ophthalmologist's sole responsibility for the management of his case. A duplicate copy of the results of each serial testing appointment would be coded and filed at the facility. This accumulated data would eventually provide a means of valid comparison of large groups of glaucoma patients managed according to varied techniques.

The response of Baltimore ophthalmologists to this proposal four years ago was not sufficiently enthusiastic to establish the facility. The most common objections to the proposed facility were that it did not seem *necessary* (most ophthalmologists apparently consider their present management techniques adequate) and that it would lead to a change in the patient-doctor relationship.

Letters explaining the proposed testing station were sent to several outside experts in glaucoma. Some of their comments may be of interest here. Dr. Bernard Becker wrote, "I am in complete agreement with your overall plan for

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the management of glaucoma patients"; and Dr. Robert Schaffer wrote, "There is no doubt as to both theoretical and practical merit of such a plan as you propose." Dr. Paul Chandler, disagreeing with the emphasis in 1960 on diurnal tension measurements, further responded, "No one knows better than I how poorly, in general, glaucoma is treated . . . If you establish such a center there (Baltimore), you might eventually raise the whole standard of glaucoma treatment in your area, and could do nothing but good." Thus, there was considerable discrepancy between the majority opinion of local practicing ophthalmologists and nonresident experts in the glaucoma field.

There were other major objections raised to the concept of a glaucoma facility as outlined above. One noted ophthalmologist wrote: "I believe that at least in private practice few patients would care to trust the recording of tension to technicians, nor do I feel this should be encouraged." Another commented, "As long as this remains a hospital experimental projection I can understand the value of such an undertaking, but once you begin to hire an office in a downtown building, I can easily visualize commercialization by other groups who would have a perfect right to organize such a checking station."

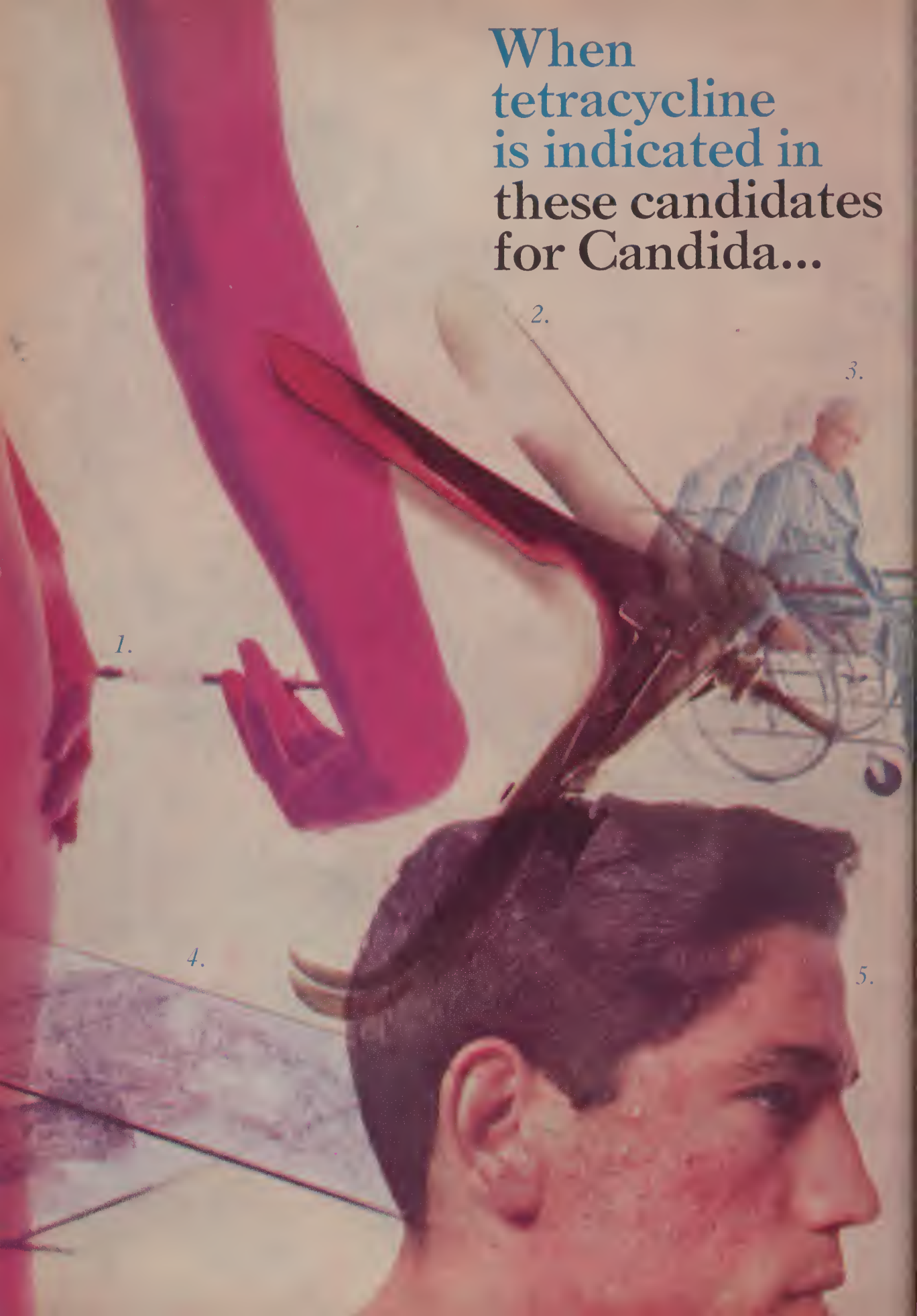
That last comment undoubtedly referred to a group such as the optometrists, who have a legal eye on what might be permitted to technicians but not to them. *Optometrists must not test for or treat glaucoma.* The pertinent differences between them and medical technicians is that the latter work only under the supervision of the medical profession and do not participate in the medical management of a patient. These medical assistants have become as crucial to the modern ophthalmologist as a physiotherapist is to the orthopedist, or an x-ray technician to a radiologist. It is true that all of these skilled workers are entrusted with potentially hazardous duties. If ophthalmic technicians are legally prohibited, we will be unable to cope with our growing responsibilities for the complete care of each patient that we examine.

In summary, the idea of a separate glaucoma testing facility for a large community depends upon the performance of technical skills by non-ophthalmologists. The interpretation of the test results, the prescription of medicine, and the decisions on medical or surgical management must always be the sole task of the ophthalmologist. So long as the facility proposed here is directed by ophthalmologists, the actual performance of tonometry, tonography, and perimetry by trained technicians would hardly differ from what is now customary in many ophthalmic practices.

It has now been over four years since the testing station idea was proposed in Baltimore; perhaps majority opinion has since changed and the need for such a facility will now be recognized. Once one is convinced, as I am, of the general inadequacy of present glaucoma management, one must concede that there are too few ophthalmologists to perform the continual retesting that each patient deserves.

Practical solutions should keep pace with present knowledge and present needs. Today we turn our thoughts to glaucoma surveys and to basic research; likewise, we must soon design efficient and effective ways to manage, *with optimal medical scrutiny*, the million patients who have this chronic disease.

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PROSTATITIS—A review of the changing concepts in the causes and treatment of acute and chronic prostatitis. The physiologic factors in the disease process are delineated. The role of surgery in this disease is clarified, and the relationship of prostatitis to benign prostatic hypertrophy is noted. A brief outline of therapy is given.

PAUL BORMEL, MD

Prostatitis is the cause of many perplexing abdominal, rectal, and genital complaints. It has long been an enigma to both patient and physician because of the many ways in which it presents itself and of the difficulty in treating it successfully.

During a one-year study of chronic prostatitis, Edward Gartman[4] listed more than 178 different symptoms involving every system from the hair of the scalp to the tips of the toes. The usual symptoms, thin, watery urethral discharge, perineal discomfort, and vesical irritability (urgency, frequency, dysuria, and nocturia), are easily recognized; however, the subtle symptoms, such as decreasing libido, feeble erections, and what the patient refers to as the "early morning dew," are becoming increasingly appreciated as due to low-grade prostatic infection.

Etiology

In the earlier textbooks of medicine and urology one finds the statement: "The commonest cause of prostatitis is *Neisseria gonorrhoeae.*" Advantage was taken of this in the old days when a person was a suspect of gonococcus (GC) without a discharge. He was given lots of beer or alcohol to stimulate his gonococcal prostatitis or urethritis to produce sufficient secretions for a urethral specimen to verify the diagnosis.

In recent years the venereal cause of prostatitis has been disappearing from the standard medical text and is being replaced by concepts founded on newer medical knowledge.

Acute prostatitis as observed today frequently begins as an accompaniment of a venereal disease. A young man at the time of the initial contact with the gonococcus organism may also be inoculated with staphylococcus, streptococcus, *escherichia coli,* or any of the host of other organisms present in the vagina. The gonococcus produces an inflammation in the urethra and prostate, allowing other organisms to establish secondary infection in the absence of the protective response of the normal, healthy tissue. The venereal disease is successfully treated with penicillin, but the urethral discharge may continue or subsequently recur several weeks or months later. This is not to be confused with the Mimea infections, which also appear as gram negative diplococci but which can be differentiated culturally

from gonococcal infections (aerobically cultured on E. M. B. agar).

A second source of acute prostatitis, not requiring a precedent venereal disease, is an antegrade urethral infection. This may occur during intercourse when a posterior urethritis is present which originated from a bladder infection. Again, the normal protective mechanism of the prostate is reduced, allowing infection to occur.

Hematogenous spread of infection in most young men is an infrequent source of prostatitis. Although it has a rich blood supply, the prostate is seldom involved in conditions which become systemic to the same extent as the kidney or lung.

Chronic prostatitis is due to an ascending urethral infection, becoming entrenched in the depths of the prostate. It tends to become recurrent and refractory because of the virulence of the organism, inadequate initial treatment, inadequate local tissue response, or fibrosis. Anyone who develops acute prostatitis is subject to chronic prostatitis if the initial response of the prostate is inadequate to cope with the infection.

Prostatic Physiology

The sole apparent function of the prostate is external secretion. The prostate gland manufactures and stores fluids which convey sperm during copulation. There is no convincing evidence that the prostate may also produce hormones. In addition to producing a vehicle, seminal fluid furnishes extracellular foodstuffs for sperm, thus supplementing the intracellular nutritional reserve.[6] The average male secretes 0.5-2cc of prostatic fluid a day, most of which is eliminated with the urine.[3]

Prostatic secretion is primarily a function of androgenic activity (testosterone) and secondarily of chemical and nervous stimulation. Such drugs as pilocarpine hydrochloride will increase prostatic secretions. Stimulation of the hypogastric nerves and the nervi erigentes induces prostatic secretions. According to Hugh Young,[2] it is difficult to clinically separate infections of the prostate from those of the seminal vesicles.

Alcohol causes congestion of the prostate, increasing the symptoms and tendency to "overflow" with secretions. Alyea[2] has suggested that alcohol and irritative condiments may aggravate chronic prostatitis via its irritant effect on the posterior urethra.

Treatment

The principles of treatment of acute prostatitis are:

1. Bed rest
2. Antibiotics
3. Sitz baths
4. No urethral instrumentation, prostatic massage, or intercourse
5. Aspirin
6. Adequate fluid intake
7. Mild laxative

Bed rest and antibiotics are of paramount importance in treating acute infections of the prostate. Sitz baths provide heat to aid healing in the infected, localized site of the prostate. Hot enemas, diathermy, electrical pads, or electrodes in the prostate are alternate methods of obtaining heat to the area of the prostate.

The principles of treatment of chronic prostatitis include:

1. Antibacterial agents
2. Warm sitz baths
3. Avoidance of alcohol, spicy foods and black coffee
4. Prostatic massage
5. Psychological support
6. Frequent intercourse
7. Mild laxatives

Antibacterial agents are used if large accumulations of leukocytes are present. Suppressive doses of nitrofurantoin, 50mg, four times a day; sulfisoxazole, two tablets (0.5 grams) four times a day; or methenamine in the same dosage can be used. Antibiotics will not cure the condition. At best, the infection is simply suppressed with milder agents, since it is a chronic condition. The effect of frequent and changing antibiotics merely increases the resistance of the organism or makes the patient susceptible to the various complications which can occur on long-term antibiotic treatment.

With regard to warm sitz baths, the same comments apply as were mentioned for acute prostatitis. Usually the patient sits in a tub of warm water every night for 20 to 30 minutes. Alcohol, spicy foods, and black coffee are eliminated because of their irritative effect. Prostatic massage should be gentle. Rough handling of the prostate not only will aggravate the condition but also

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will cause you to lose a patient from a treatment which he sorely needs.

Psychological support is of paramount importance in the treatment of this chronic disorder. Once the nature of his problem and its chronicity is explained, the patient is able to live more comfortably with his illness. Karl Lewin[5] and Edward Gartman[4] have stressed the importance of the psychosomatic aspects of chronic prostatitis. Although the value of prostatic massage cannot be minimized, the possibility of aggravating a pre-existing psychologic or erratic disturbance which may be focused in or around the prostate must be considered. Prostatic massage is not a substitute for frequent intercourse, which is an integral part of the treatment of chonic prostatitis.

Role of Surgery

Since prostatitis involves the *true prostate*, surgical extirpation is not ordinarily indicated. A radical prostatectomy would be necessary, which carries with it all the risks of a major surgical procedure plus the possibility of impotence, incontinence, stricture, or possible fistula formation.

A transurethral resection usually is not indicated because it would intensify the patient's symptoms unless all prostatic tissue is removed. This is difficult to achieve even by the best surgeon.

Relationship to Prostatic Hypertrophy

Prostatitis and prostatic hypertrophy are independent entities and usually exist in different age groups. A large obstructing prostate gland with residual urine in the bladder may become infected and form microscopic foci of chronic prostatitis. Chronic prostatitis, however, does not require prostatic hypertrophy to initiate the disease process, or vice versa.

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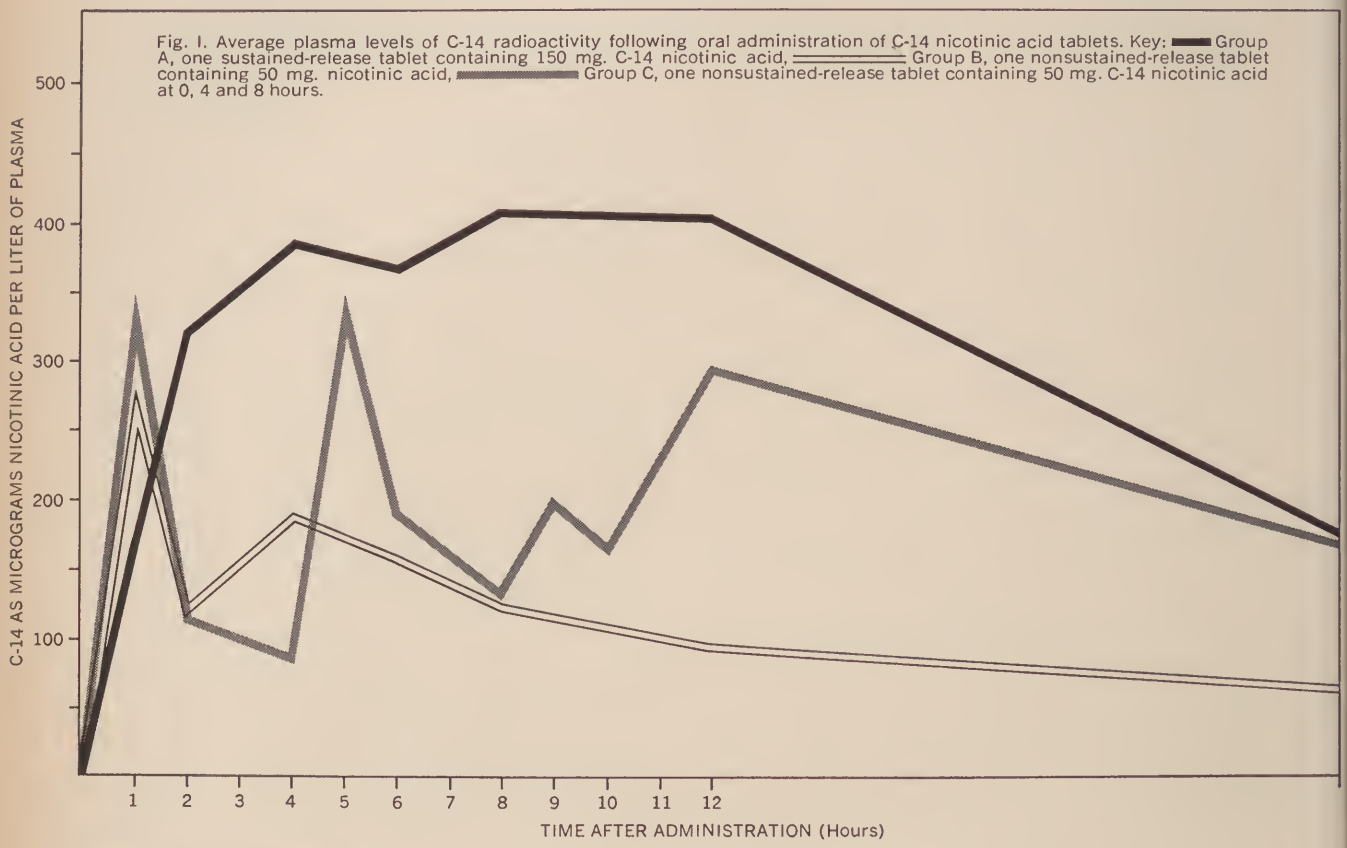
Methenamine—*Mandelamine*
Nitrofurantoin—*Furadantin*
Sulfisoxazole—*Gantrisin*

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Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





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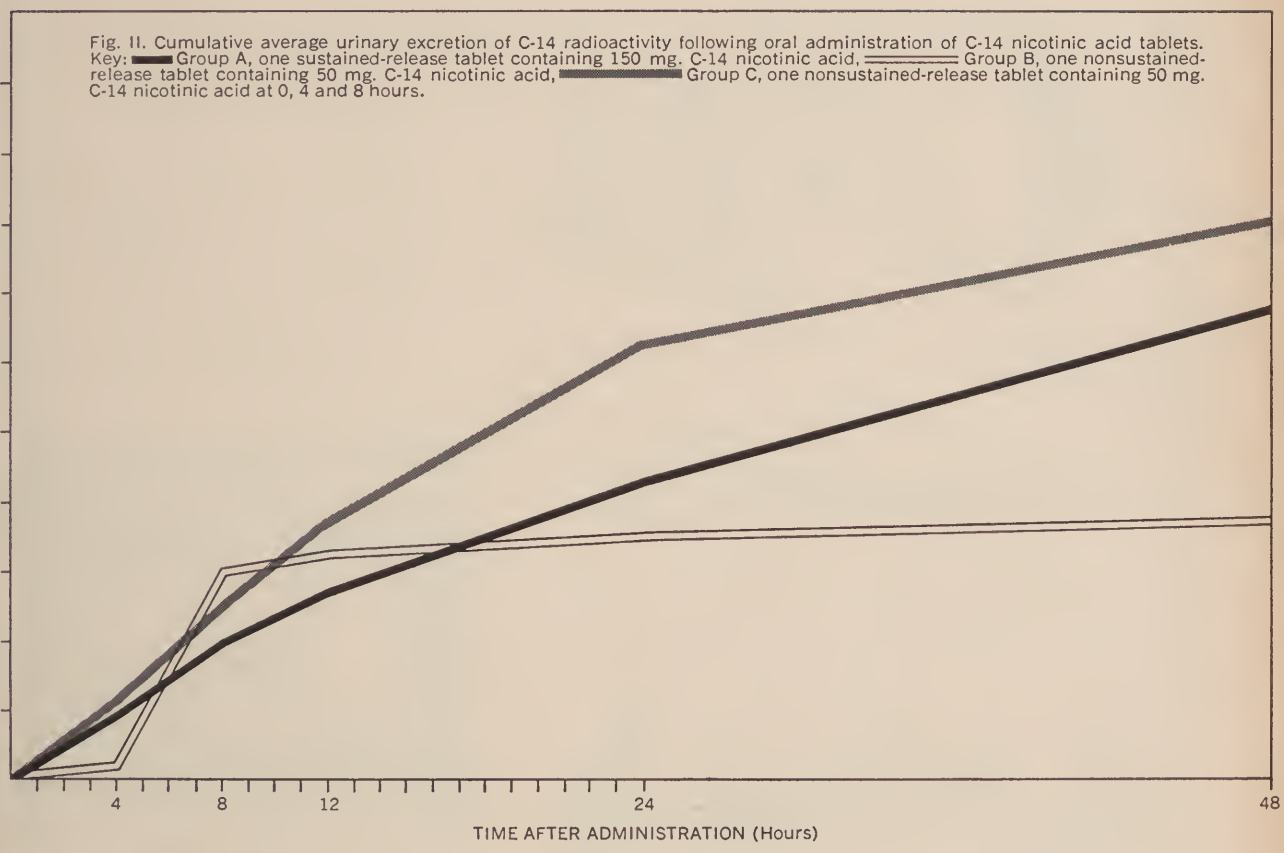


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

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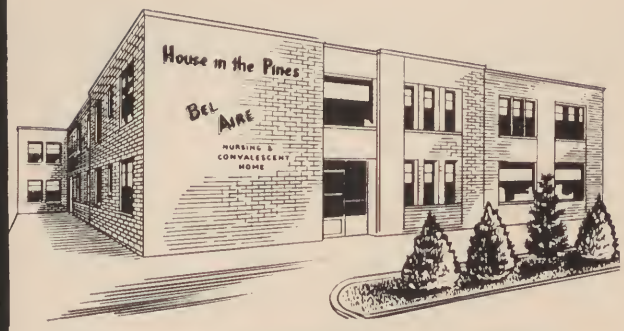
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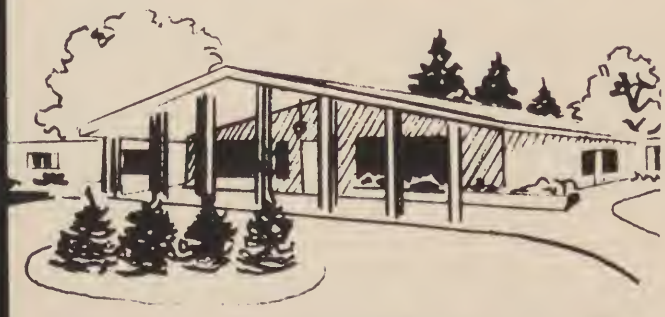


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The nursing profession has permitted the clinical tradition to decline while attention was focused on education, the development of administrators, teachers, and research workers. The student nurse interested in clinical nursing has no goal of attainment or recognition in clinical nursing. It is proposed that a graduate program or school of clinical nursing be organized within the structure of the school of nursing. There should be a goal of attainment in the field of clinical nursing that will offer a lifelong challenge to the interested, capable, and intelligent nurse.

CLINICAL NURSING

O. C. BRANTIGAN, MD

Thomas Sydenham wrote, "The primary aim of medicine is the care of the patient." The direct immediate care of the sick patient is clinical medicine; it is clinical nursing. Facts discovered and collected by scientific research are important to the sick patient only when properly applied to his particular disease and to his individual variation from normal over and beyond his specific illness. Scientific information must be perused, sorted, and those facts applicable woven into a pattern of treatment that can be administered to the individual patient who is ill. The proper assessment of the condition of the patient and the proper timing of intervention is the work of the clinician; and only the clinician has developed this skill by closely working with sick patients.

The medical and nursing professions have made tremendous strides forward in the past 20 years. In the past decade, because of a twentyfold increase in funds for medical research, research science has been overemphasized with a falling off of attention to clinical medicine.[1–3] The increased work of administering the large research sums of money and the lack of attention to the clinician has led to less effective medical school teaching in the

clinical field. In the nursing profession, there has developed a host of ancillary help: the nurses aide, the ward clerk, the dietetic aid, and so on. This development, though sorely needed, has not freed the nurse for more needed work. It has accentuated the need for the nurse administrator. It is a good example of Parkinson's Law or the rising pyramid.[4]

The nurse administrator must continue to supervise the nurses; but, in addition, the nurse in charge of a ward or area must be competent to direct, control, and supervise the group of aides who often are not of the highest intelligence and surely are not dedicated to the work. The nursing profession is to be complimented for the development of administrators with a high degree of skill.

The nursing profession has interested itself in research, and there is promise that great programs will be developed in the near future. The favored word throughout our great nation is *research*. It is to be fostered but not to the detriment of other needed areas of development.

In the nursing profession, much effort has been directed to the development of teachers. Teachers have been developed within their own ranks, and perhaps this has been one of the greatest achievements of the nursing profession. Interest in and the development of teachers has brought about an enormous improvement in the education of the student nurse. It can be seen in the increasing numbers of baccalaureate and nursing degrees that are being conferred and in the increased activity of colleges and junior colleges participating in the teaching of basic science to the nurses.[5]

The general improvement in education is admirable. It makes a better qualified and better oriented nurse. However, the teaching of a clinical nature and teaching of clinical material by the doctor of medicine has been neglected or at least has failed to make advances commensurate with teaching in other areas. With interest of the nursing profession focused upon administration, research, and teaching, the field of clinical nursing has failed to advance. The cause is similar to or parallel to that found in the medical profession in its failure to advance clinical medicine.

The nursing and medical professions are so closely allied that one is completely dependent upon the other.[6] It is folly to believe that one could exist without the other; yet it seems that in the past 15 to 20 years there has been an ever-widening chasm between the two. Perhaps in some way it is related to the failure of both to put proper emphasis upon improving and developing top flight clinicians. It is obvious that the doctors and their organizations should interest themselves in the problems of the nurse. They should help and support the nurse in developing an adequate goal of attainment worthy of the interest and ability of the intelligent, capable nurse and to help the nurse in securing appropriate economic reward for the important work that is done.[7]

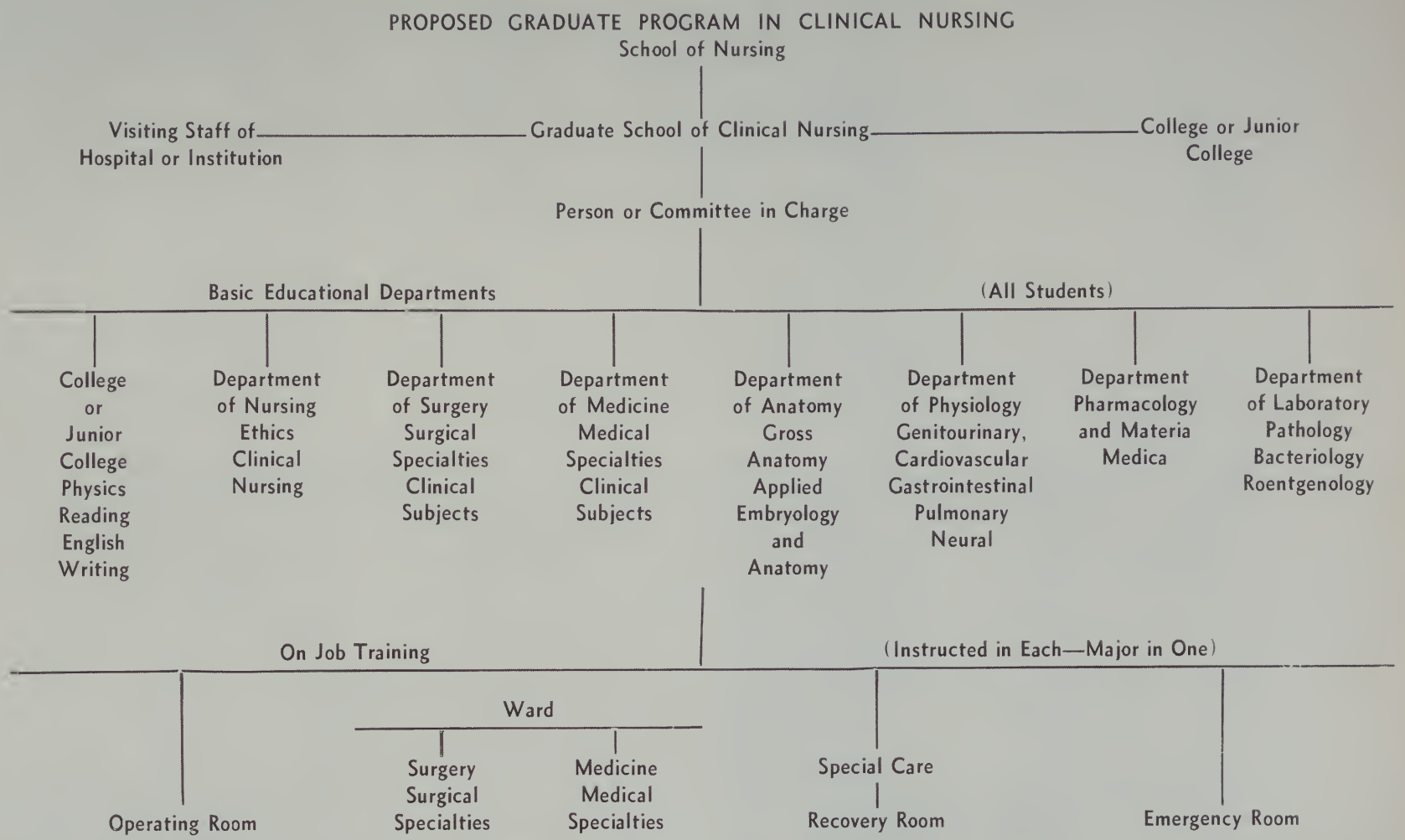
Re-emphasis on teaching clinical material to the student nurse and the development of a recognized and well-organized graduate program for clinical nursing might well be the catalyst that will reunite the two professions. The doctors of medicine should participate more actively in the teaching of student nurses and should carry the major burden of teaching in a proposed graduate school of clinical nursing. The renewed association and mutual activity would close any breach in the relationship between the two great professions and would in time draw them into an inseparable amalgamation of purpose and accomplishment.

It would be easy to incorporate more and renewed effort in the teaching of clinical nursing to the student. The development of a graduate program or school for teaching of the art and science of clinical nursing would be more difficult. After many years of study, aided by able clinicians in both medicine and nursing, a skeletal outline of a proposed graduate program or school of clinical nursing is presented in the Table.

The philosophy of the program is to bring capable workers into a system that will provide the best possible treatment and care of the sick patient and, at the same time, provide a fitting lifelong career that will challenge the best efforts and intellect of the capable nurse.

The purpose of the program is to improve the care of the sick patient and to give additional education and training to the capable graduate registered nurse in order that the nurse can, through proper training, exercise greater responsibility in the care of the sick patient, but always under proper medical supervision.

The proposed graduate program must be under the direct control of a recognized (accredited) school of nursing, but doctors in clinical practice should have an important role in the advisory committee or council. It is desirable to have an affiliation with a university, a college, or a junior college. The faculty thus would include a selected


PROPOSED GRADUATE PROGRAM IN CLINICAL NURSING
School of Nursing
Visiting Staff of Hospital or Institution
Graduate School of Clinical Nursing
College or Junior College
Person or Committee in Charge
Basic Educational Departments
(All Students)
College or Junior College Physics Reading English Writing
Department of Nursing Ethics Clinical Nursing
Department of Surgery Surgical Specialties Clinical Subjects
Department of Medicine Medical Specialties Clinical Subjects
Department of Anatomy Gross Anatomy Applied Embryology and Anatomy
Department of Physiology Genitourinary, Cardiovascular Gastrointestinal Pulmonary Neural
Department Pharmacology and Materia Medica
Department of Laboratory Pathology Bacteriology Roentgenology
On Job Training
(Instructed in Each—Major in One)
Operating Room
Ward
Surgery Surgical Specialties
Medicine Medical Specialties
Special Care
Recovery Room
Emergency Room

number of teachers from the school of nursing and members of the affiliated institution of higher learning; however, most of its faculty members should be doctors who are engaged in the clinical practice of medicine.

Details of time spent, exact subjects studied, and number of faculty has been worked out and should be variable. The nursing school with its faculty would occupy an important sphere of teaching. The university, college, or junior college affiliation would teach basic physics in order that the student would better understand the complicated machines now employed in the treatment of patients. The student would study reading, writing, and English for the educational advantage and for aid in accomplishing the record-keeping necessary in the new duties.

The departments of medicine, surgery, and their specialties can be enlarged or curtailed as desired. Obviously, the faculty members could be recruited from the doctors practicing in the respective clinical field. The department of anatomy should teach gross anatomy and applied embryology and anatomy from cadavers. Anatomy should be taught by a doctor in the clinical practice of medicine who has a special interest in anatomy. The department of physiology could be outstanding. The subjects should be taught by doctors who are specialists in the respective fields. For example, the specialist in obstetrics and gynecology would teach the physiology of female reproductive organs and excretory system. The specialist in male urology would teach physiology of the male genitourinary system. The department of pharmacology and materia medica would be taught by internists who are especially adept in their use of basic and important medicines. The department of laboratory would be taught by the doctor or doctors in charge of the various areas, such as pathology and roentgenology. In all areas, the teachers will be clinicians expert in their fields of endeavor, and they will keep their instructions on a practical clinical basis, never forgetting that basic knowledge allows variation in practical application. All students would participate equally in the basic subjects outlined.

The on-the-job training areas or departments would be in charge of the regular nursing supervisor and the doctor normally designated as head of the particular area. The teachers or faculty members would be the doctors in clinical practice in the area and nurse teachers especially prepared for the duty. It is in this clinical area that the scope and responsibility of the nurse should be greatly expanded under proper medical supervision and control. The nurse would become an assistant or associate of the doctor in charge of the patient.

It is believed all students should have a brief period in each of the areas, but the student should specialize (major) in one area in order to attain maximum efficiency in the chosen field. It is suggested that the registered nurse graduate from the course be called a clinical associate nurse in the field in which the major study was taken. The details of the subjects taught have been worked out but are too lengthy for a description here. The graduate clinical associate nurses will take up duties in their respective areas of specialization. It seems imperative that the clinical associate nurse be under the control of the supervisor of nurses in the area; however, the doctor in charge of the area must have authority in assigning the duties and supervising the work done by the graduate clinical associate.

The duration of the course of teaching should be one year. It seems impossible to develop a person with adequate skill in less time. Success of the program demands that the graduate must be an able, intelligent, and well-trained person. No other person should be admitted to or graduated from the program.

The entrance requirements should be rather exacting, since it is believed that only the exceptionally capable graduate nurse from an accredited school of nursing should be admitted to the program of advanced training. The quality of the graduate from the program can be controlled to a great extent by the careful screening of those permitted to undertake training.

It seems that any accredited hospital of 300 to 400 beds that has an accredited school of nursing could organize such a program, since the desired faculty and clinical material would be available. If the program is developed under nursing authority there would be assurance that diploma mills could not occur.

The concept of a specially trained capable nurse being allowed to carry out duties and treatments now restricted to the doctor is worthy of honest, deliberate, and exhaustive study, consideration, and discussion.

The following are natural areas for study and discussion. Is the proposal legal? Will it be ac-

cepted by the accrediting agencies, the nurses, the medical profession? Will the nurse shortage be aggravated? Is the program needed? Is the material to be taught the same material that should be taught to the student in nursing? Obviously, many other questions could be considered.

The legality of the increased duties and responsibility of the graduate clinical associate is always uppermost in the minds of administrators and nursing leaders. It cannot be illegal to give additional training to persons qualified to accept training. The doctor who assumes the responsibility of treating a patient will continue to exercise that responsibility. The right (legal) of the clinical associate to administer to the patient will be acceptable so long as the medications and treatment are at the specific order and direction of the physician who is responsible for the patient, even though the care and treatments are in a category not now ordinarily performed by the nurse. Presently, the nurse can and does carry out orders of the responsible physician.

It is fair to presume that precedent and common practice must be seriously considered when the nurse is to be given advanced training to permit increased responsibility. There are schools teaching anesthesia to nurses who, when graduated, administer general and other anesthetic agents. The Johns Hopkins Hospital has a school of midwifery open to nurses interested in obstetrics.

By using increased responsibility, help in the care of the sick or injured patient is now carried out extensively throughout the United States in the office of doctors, in first-aid departments of industrial plants, in the armed services, and in almost 6,000 hospitals without house officers.[8] The responsibility and duties of the nurse serving in these areas are far greater than in the hospitals where there are house officers. A survey in these areas indicate that the nurses permitted to and encouraged to execute increased responsibilities are proud of their ability and work. Satisfaction of attainment is the reason they are working in their particular area. Many denied the right would leave nursing for other more challenging pursuits. However, it is most important to realize that the nurses assuming the increased responsibility in the care and treatment of the sick or injured are doing it under the direction of the physician responsible for the care of the patient. It is also well to realize that these nurses have had no formal or organized training in their field of increased responsibility. The new, intensive treatment wards are capably manned by nurses of this category. The proposed program merely suggests that these excellent and capable nurses be given the opportunity of formal recognized advanced training in the duties they are called upon to carry out in the care of the sick or injured patient. It merely asks for recognition of a practice prevalent throughout the United States. It suggests that these unusual nurses be permitted to do their fine work in the care of the sick patient with the blessings of all concerned. The graduate clinical associate will not be asked or called upon to make decisions except within the confines laid down by a discussion with the physician responsible for the particular patient.

There will be no direct answer to whether or not the accrediting groups will accept the program until a detailed program is drawn up and submitted to the proper organizations; for example, the National League for Nursing, the American Nurses' Association, the Joint Commission on the Accreditation of Hospitals, the Council of Medical Education and Hospitals of the American Medical Association, and to the state and national medical societies. It seems none would object to better training for persons administering to the sick or object to improving the care of the sick patient. In an unofficial discussion with an important council of the American Medical Association, a pilot study of the program was encouraged. Hudson, a member of the Council on Medical Service of the American Medical Association suggests a program of training using basically less able and less well-trained personnel than the graduate nurse.[9]

If the acceptance of the program is further discussed, several important impressions can be brought out. The rank and file of graduate nurses are interested in the program and many are enthusiastic about the prospect of being permitted a greater field of service and responsibility brought about by the opportunity of additional training. The administrators of nursing schools are reluctant to accept the program, but it would be unfair to state that they are not interested. In addition, Francis Reiter has urged that nurses assume more active roles in their relationship to physicians by freely sharing observations, interpreting patient reactions, and offering suggestions for patient care.[10] The method of control of the

clinical associate and the relationship of the regular graduate nurse seems to be a cause for misgivings in the minds of directors of nursing schools. The clinical associate would be on a level with the operating room supervisor or the supervisor of an area, but, when working in an area, the clinical associate would be under the authority of the nurse supervisor, very much the same relationship of a nurse-teacher who works with student nurses on a particular ward or area.

All who are acquainted with the problem of nursing agree there is a shortage of nurses. It is said that the answer to a shortage of nurses is not to enlarge their sphere of activity, thus creating an additional demand upon the already chronic shortage. Such a viewpoint, however, is a short-sighted approach to the problem. If the goal of attainment for the nurse is enlarged to include clinical nursing, and a position in clinical nursing made worthy of the best talent in the intelligent, capable nurse, there will be numerically more and also more capable and intelligent students attracted into the field of nursing. The young person dedicated to helping humanity will be able to enter the noble profession of nursing and know there is a place of recognition and attainment other than in administration, teaching, or research. There will be the rewarding field of clinical nursing. A recognized sphere of attainment in the field of clinical nursing is now practically nonexistent. It is difficult, if not impossible, to know how many nurses drop out of work in the nursing profession because they cannot advance in the field of clinical nursing.

It is interesting to speculate upon the number of professional graduate nurses in the United States and its territories who may or may not be employed in their profession. In 1950 there were 374,584 professional graduate nurses employed. In 1960 there were 504,000 professional graduate nurses employed, of which 90,000 were working part-time.[5] From 1950 to 1960 there were graduated approximately 317,221 nurses.[11–16] The number employed increased 129,400. The increase is only about 41% of those graduated. If one considers those who died and those who retired by becoming overage in the 11-year period, it will roughly amount to about 66,000, or about 21% of the group graduated during those years.[17] Based upon these figures and interpolated for the past years of existence, one can roughly estimate that the group of professional graduate nurses not employed in nursing equals approximately 40% of those employed. Why this large group is not employed in the nursing profession can at best be only speculation. Of 191,925 not employed in nursing when studied by the American Nurses' Association 85.7% were married, while 6.8% were over 59 years of age.[5] Of the group of graduate nurses not employed in nursing perhaps many would re-enter the field of nursing if a program of advanced training in clinical nursing were open to them.

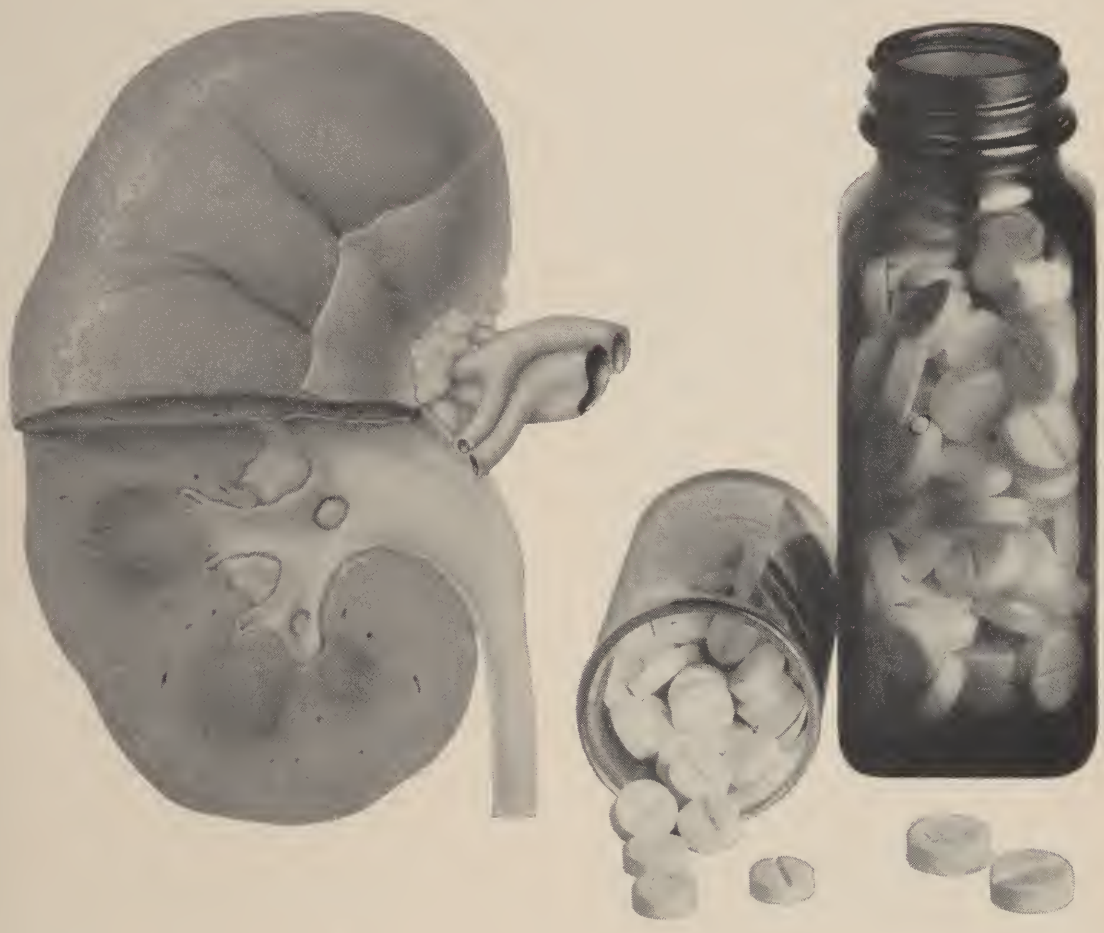
It has been said that if the student nurse were properly taught and the profession properly oriented there would be no need for a special program to develop the specialist such as the clinical associate in nursing. Obviously, this is far from the fact. All student nurses will not have a desire to develop beyond the fundamentals of nursing, and perhaps many are without the native ability to do advanced nursing. A number of student nurses will aspire to become experts in the field of administration or teaching, and the future will see those who will desire to go into research. The plea is to continue the present high standards of education and teaching in nursing and to enlarge the sphere of nursing by providing a field of advanced teaching in clinical nursing.

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Baltimore, Md. 21201

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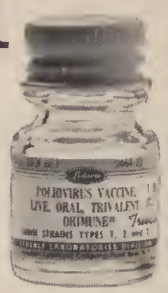
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Contraindications: Salutensin is contraindicated in severe depression.
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Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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THE LEGAL SOLUTIONS TO PROBLEMS IN DAILY MEDICAL PRACTICE

GEORGE D. SOLTER, ESQ.
MAX R. ISRAELSON, ESQ.
Moderator: RUSSELL S. FISHER, MD

The Good Samaritan Act
Lawyer-Doctor Liaison in Trial Work
Emergency Medical Calls—The Doctor's Liability
Reporting Medically Unfit Automobile Drivers

DR. FISHER: As you probably know, I am Dr. Russell Fisher and will moderate this session this evening. It is a presentation of the Joint Committee of the Medical and Chirurgical Faculty and the Bar Association of Baltimore City and the Maryland State Bar Association. This committee, which has been in existence now for 12 or 14 years, is divided into three subcommittees: the one on Interprofessional Relations, the one on Court Procedures, and the one responsible for your evening's entertainment—I hope—the Subcommittee on Symposia Management. The chairman of the overall committee for the legal side is Mr. Theodore Waters and for the medical side, Dr. John Classen. Your panelists this evening are Mr. George D. Solter and Mr. Max R. Israelson.

Mr. Solter is a Baltimorean, educated here in primary schools, at Johns Hopkins University, and in law at the University of Maryland. He was assistant state's attorney for some four years, from 1950 forward, and then retired from this post to enter trial practice, in which he has been engaged since 1954. He is a partner in the firm of Due, Nickerson, Whiteford and Taylor, and we will direct specific questions to him as time goes on.

Mr. Max Israelson is also a native of Baltimore. He also was educated in the primary schools in Baltimore, spent some time at the University, and studied law at the University of Baltimore. He is a member of the City, State, and American Bar Associations and former national chairman of the Personal Injuries Section of the National Association of Claimants Counsel of America. He is a former president of the Maryland Plaintiffs Bar Association. He is a member of the Joint Committee on Medicolegal Problems, which sponsored this whole series of meetings. He served as assistant city solicitor when the late Judge Simon Sobeloff held the post of city solicitor; is in the private practice of law in the city.

The subjects to be discussed are listed, and without further ado, we will get directly into the business of the evening. We will not follow the exact order in which you see them printed, but I will start it off by asking Mr. Solter about the Good Samaritan Act, which the legislature passed and the Governor signed in a recent session.

Would you define this act and state what effect it has on the doctor's obligation to render aid at the scene of an accident and his liability for alleged negligence on rendering such aid.

THE GOOD SAMARITAN ACT

MR. SOLTER: First of all, I am sure most of you have some idea what the Good Samaritan Act or law is. To state it simply, it is a law that is designed to free the physician from liability when he stops in good faith to render aid in an emergency.

One might ask why it is necessary to have such a law. Contrary to public belief, it is not because there has been a rash of malpractice suits

Medicolegal symposium presented May 9, 1963. Arranged by the Joint Committee on Medicolegal Problems.

directed at doctors under such fact situations; it is more the fear that such would be the case that has made it necessary for several of the legislatures in the country to consider whether such an act would be advisable and helpful as a matter of public policy generally.

Since the end of the last war there has been in this country a marked increase generally in malpractice claims and suits. I am not referring now to the emergency aid situation that we are dealing with, but in a general sense there has been an increase of about 14 per cent, according to the American Medical Association. As a result of this, most doctors—29 per cent, according to a survey of the Association—have covered themselves with some form of liability insurance, in varying degrees of coverage, in the event they are sued or claim is made against them on the basis of malpractice.

Of course, the continued growth in the number of malpractice claims has caused an increase in the insurance premiums, and in some instances, in some areas, which I believe Mr. Israelson will discuss with you, it has been a considerable hardship, because it seems that there is some sort of geographical character about these malpractice claims and suits and causes the premiums to go up. Yet they are affected generally, although most of the claims are in certain specific areas of the country.

Research indicates that actually there are very few claims that arise out of emergency care rendered by a passing physician at the scene of an accident or in some other circumstance where the normal doctor-patient relationship would not have an opportunity to exist.

The increase in claims in malpractice suits has brought about an awareness on the part of doctors which has, in turn, generated in them a fear that they should not stop and get involved. They fear that they will be charged with a hasty and incomplete examination, with improper treatment, with a failure to follow an accepted or standard procedure in a given situation, with assault and battery for failure to obtain consent, and with not following a case to a conclusion. After the doctor renders aid, the ambulance arrives and takes the patient off to the hospital, and the doctor doesn't follow up, which would seem perfectly natural once he is in the hands of an attendant or at least delivered to the emergency room. But doctors have been sued for failing to follow a case once they have undertaken to treat it.

There are valid reasons for their fear, I think. Some fear that the lack of proper equipment at the scene of an accident will hamper them; they fear that under the circumstances, they will have to exercise an immediate matter of judgment on a situation that they are not totally familiar with; or they fear that perhaps their own specialty has not equipped them, since the days of medical school, to handle the situation they may run into at an emergency.

There is some opposition to this law even among lawyers. They fear that perhaps this law sets up a special shield for doctors, whereas it does not pertain to a lay individual. Doctors are being protected in a situation where they above all are more equipped and ready to handle a situation than a lay person would be. In substance, they feel that the law should read "any person," and not just doctors, who stops and renders aid should be protected by the statute.

The pressure of this problem in the last few years has culminated in the passage of statutes of this type in 15 states. There may be one or two that have passed it in the last few months that I have not been able to pick up, but at the beginning of 1963 there were 14; and I know that Maryland has now joined the list.

The California statute was the first one to be passed, in 1959, and is the forerunner. It really is the simplest, and I will read it.

> No person licensed under this chapter who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of acts or omissions by such person in rendering the emergency care.

When it refers to "no person licensed under this chapter," it is referring to doctors, nurses, and the like under the medical chapter of the California Code. That does not mean any person generally.

In 1961 and 1962 the other states followed along. They vary in the actual wording and context of the statute, but basically most of them follow the California pattern. In Maryland, in 1963, the legislature passed Senate Bill No. 117, which the Governor has signed and which will become effective on June 1, 1963.

That statute reads as follows:

> A physician licensed to practice medicine by the Board of Medical Examiners of the State of Maryland, who in good faith renders medical aid, care not in a hospital, and assistance, for which the physician receives no fee or

compensation, at the scene of an accident, shall not be liable for any civil damages as a result of any professional acts or omissions by him, not amounting to gross negligence. In rendering such aid, care and assistance, the physician shall have the defense against any action not amounting to gross negligence, for negligence or malpractice brought against him because of any professional acts or omissions in the rendering of such care, aid and assistance.

Right off the bat you see that our legislature has inserted an exception in the form of gross negligence. In other words, you are protected from ordinary negligence but not from gross negligence. This opens up a big area of what is gross negligence. All I can do is tell you what our Court of Appeals has said about it and define it. Usually it comes up in connection with the operation of a motor vehicle or some other instrumentality that is capable of rendering harm and injury. Nevertheless, for what it is worth, these are some of the definitions that have been given for gross negligence.

It is the omission of that care which even an inattentive and thoughtless person never fails to take of his own property. It implies malice and evil intention. Gross or criminal negligence is a wanton or reckless disregard of human life.

The word "wanton" means characterized by extreme recklessness and utter disregard for the rights of others.

Conduct to be in reckless disregard of the safety of others must not only be done with the knowledge of the risk involved but with perception of the extent thereof and realization that the conduct involves a high degree of probability that substantial harm will result from it. An attempt to discharge a high moral duty cannot be termed negligence unless the actor's conduct exhibits such a reckless indifference to danger as amounts to rashness entailing almost certain injury.

That last sentence, I think, certainly should apply in the case we have been discussing. Frankly, I think this whole thing is a big tempest in a teapot that his been grossly exaggerated. Records of the courts and the medical societies show there are very few instances where any such claims have ever been brought, and yet these statutes have been brought about because of a fear on the part of doctors that they will be brought.

Perhaps the statute will relieve the minds of some at least while in Maryland. I don't know whether they will have any list they can check as they pass from one state into the next to make sure they can stop in West Virginia, for instance, and help somebody or not. But suffice it to say, in my humble opinion, I think the need for the law is greatly exaggerated; but since it has now come on the statute books, I think it is probably one of those laws that eventually should be turned over to the American Bar Association for conformity so that it would be uniform in all states.

If anybody is interested in a capsule comment on the subject, I suggest you read the May issue of *Reader's Digest*. There is a fairly short and concise article on the point there.

DR. FISHER: Mr. Israelson, would you like to comment on this act.

MR. ISRAELSON: Mr. Solter has covered it most thoroughly. The only note I would make on it would be to try to give a practical illustration of the remoteness of any charge or claim under this act. When Mr. Solter defined gross negligence so well, that was the legal definition. To give an idea of how it applies in law, manslaughter by automobile calls for proof of gross or wanton negligence. In Maryland, while we have roughly 400 to 500 motor vehicle fatalities in the course of each recent year, the ability to prove wanton or gross negligence is so very difficult, even in cases of the worst and most flagrant abuse of the law —such as drunken driving and driving at tremendously high speeds—that there are rarely more than possibly one, two, or three convictions in any of those cases in the course of a year.

My understanding is that the American Medical Association in one recent publication indicated there were only approximately four, five, or six of these claims throughout the whole country. I agree that it is somewhat of a tempest in a teapot, but now the medical profession is fully protected.

REPORTING MEDICALLY UNFIT AUTOMOBILE DRIVERS

DR. FISHER: Mr. Israelson, to move to the next question, it is commonly stated a significant percentage of all accidents are caused by medical disability on the part of drivers. Without debating that, would you assess for us the doctor's duty and his liability in reporting possible disabling disease in his patients to the Commissioner of Motor Vehicles. And would you carry this a little further and suggest what combined efforts on the part of our two professions you would like to see brought about in order to better protect the public in this regard.

MR. ISRAELSON: The reluctance of doctors to report medically and mentally disabled drivers to the appropriate authorities is understandable, principally reflected in the starry-eyed light of youth and of the relatively early age at which they take the Hippocratic oath, which forbids

them from divulging the communications of their patients. However, this reluctance should be weighed against the doctor's duty to the public and to the patient and, secondly, to the lack of any liability for so reporting.

Taking those two in reverse order, commenting shortly on the lack of liability: in common law, physicians, when called upon to testify as witnesses, could not decline or refuse to disclose any information on the ground that such information had been communicated to them confidentially. While this condition of the law has been looked on with disfavor by distinguished judges and by the profession generally, some of the states have enacted statutes making the communications between doctor and patient confidential. Maryland is not one of those states.

In Maryland, following the common law, doctors in court, in nonjudicial proceedings—in fact, in any others really short of slander or libel, which is of course handled under a different category—none of these really have a legal liability for divulging patient information. Basically, then, any reluctance would go to the problem of ethics.

I think that should be weighed against the duty that I spoke of, both to the public and to the patient. In the last few years the public has been keenly alerted to the physically impaired driver. Many of the magazines and newspapers have reported episodes in which a physically impaired driver has been the cause of an accident.

Time Magazine, May 3, 1960, reported the findings of Dr. Nelville Murray, a Scottish-born psychiatrist, in San Antonio, who first spoke before the American Psychiatric Association about a peace-of-mind drug that resulted in drivers' actions bringing injury to both themselves and to others.

Wide press coverage was given to pep pill abuse, from benzedrine to amphetamine. In one instance, a truck-bus crash in or near Tucson, Arizona, resulting in the loss of nine lives, was traced directly to such use, according to the report of the investigators from the Interstate Commerce Commission.

News Week, in a recent issue, gave front page coverage to a Pennsylvania law requiring applicants to present health certificates from doctors and, following that, under a new program which I believe has already been instituted in that state, organized and developed by the state secretary of health, Dr. Charles L. Wilbur, and a medical advisory committee, Pennsylvania plans to require all drivers to have periodic health examinations every ten years up to the age of 60 and every five years thereafter.

Currently Maine, Delaware, Illinois, Indiana, New Hampshire, the District of Columbia, and possibly some others in the most recent enactments of the legislatures, require complete re-examination upon renewals of driving privileges at certain ages, usually 65 or 70.

It may interest the doctors in the audience to know that one alleged authority on the subject, speaking of doctors as drivers, claims they are the most inept, irresponsible, and unprofessional of all driving license holders; their minds are elsewhere, on life and death matters; they constantly worry about finding a parking space; they are always in a hurry, rushing to a sick patient or to a hospital.

I would like to interpose a defense on behalf of the doctors. I don't think they are any worse than the average driver on the street, and probably a little better. I just feel that they are a little more conspicuous and more easily identified by the MD or the blue cross on their cars when they happen to make a driving faux pas.

The state of Connecticut was recently chosen by the United States Public Health Service for a study to determine the relationship between the health of drivers and traffic accidents. They arranged a 43-foot mobile unit, a trailer, to move around the state as an examination center. It will be used for the performance of ten different health checks, chiefly for hearing and visual impairment, diabetes, anemia, heart and lung diseases, and even driving aptitudes.

In 1958 the Florida State Department of Public Safety examined more than a half million people in that state and found that approximately 11,000 —these are drivers already licensed—failed to meet visual requirements; 31,000 needed glasses; and more than 1,300 needed special car equipment to provide for safe driving with the physical disabilities that they had. The examiners referred many persons to doctors as part of the program. Investigating certain specific accidents they had on record, more than 11,000 license holders were told to report for re-examination. Out of this group 900 failed to pass the examination, and

their licenses were taken away. About 1,200 were restricted to glasses, and 216 of these re-examined people were required to get the special equipment to enable them to drive safely.

In that same group, 800 medical reports from the medical society of Leon County were received concerning drivers suffering from epilepsy, heart attacks, diabetes, blackout spells, and alcoholism. A recommendation is being made making it mandatory for doctors to report drivers in those categories who they know to be driving automobiles.

The *Journal of the American Medical Association* recently reported a grant of $809,000 to the Harvard University, Department of Legal Medicine, for research on fatal highway collisions.

Recent medical studies show that bus and truck drivers suffer beyond the average from ulcers. The stress and strain of operating big equipment over the highways and on the city streets for long intervals and meeting pretty steady deadlines and schedules produce strains in these men apparently manifested by ulcers. When you think of that as being accompanied by the usual symptoms and evidence of this disease of abdominal pain, weakness from bleeding, the necessity for special diet, these symptoms hardly lend themselves to efficient and safe driving. Stomach cramp or spasm, anything that may cause a momentary inattention to the wheel and to what is ahead of them can follow; and of course it only takes a moment for an accident.

Sedatives, tranquilizers, pep pills, and similar drugs all add to the fatal statistics on the highway.

So much for the realization of it. The AMA's Committee on Medical Aspects of Automotive Safety discussed these points and passed its opinion. First, a physician should not determine what physical or mental conditions render a particular patient an unsafe driver. The examining physician should furnish only specific clinical information with respect to pertinent specified conditions. The determination of whether or not the patient is an unsafe driver should be left to the motor vehicles administrator. The administrator should avail himself of competent medical advice.

Several states have attempted to establish these criteria, but the responsibility, in the opinion of this committee of the American Medical Association, is that the doctor should report the medical facts. He need not assert his own opinion that the patient is or is not an unsafe driver, but they believe he has an obligation to report them to the motor vehicles authority. In Maryland that authority is the Department of Motor Vehicles.

I inquired at our department and was pleasantly surprised to find that they have a routine which lends itself to this very recommendation. They have a medical advisory board which meets twice weekly. They have 15 doctors on whom they call to attend these meetings. The number at each meeting is five. Usually these are distributed among the following specialties: neurology, psychiatry, internal medicine, surgery, and orthopedics. They then have the license reviewers, of whom there are six, and a Mr. Robinson. One of the six hears only medical cases. He advises that up to now the doctors bear out this reluctance to report; but he is hopeful, with the assurance that it not only implies no liability on the doctor but really calls for a duty on the doctor's part to do so, that more doctors will feel inclined, when they come upon these people with any disease or any disability that would make them a danger on the road, to call the Department of Motor Vehicles. Here is what would then happen.

Typically, someone will call and say, "My father is now of an age and has such a condition that he should not really drive a car. We are fearful for his safety," and of course they really mean they are fearful for his safety and the safety of others. When that happens, the DMV communicates with the person and asks him to report to their headquarters. The person is then interviewed by Mr. Robinson. He tries to elicit all medical information that might be helpful in appraising him. He gets the person to sign an authorization for release of information from his doctor or from a hospital and forwards this to the medical advisory board for review. If he feels there is an imminent danger, he will suspend that license immediately, pending review and decision by the board. If the medical board wants to see the man himself or examine him, they will call him for that purpose.

This board's recommendation to the reviewer, Mr. Robinson, is only advisory, but this advice is almost always followed. If it is suggested that his license be revoked, that is done. I think that this is a great step toward getting unfit drivers off the road.

One of the most recent public relations or advertising projects that I have seen on the billboards is: "Drive as if your family were in the other car." I think it is an excellent slogan.

I think this follows the same theme, that it is the duty of the doctor to report these people and to let a medical advisory board decide whether the highway statistics cannot be lowered by getting disabled drivers and dangerous drivers off the street.

DR. FISHER: Mr. Solter, would you take that briefly.

MR. SOLTER: Just a couple thoughts occurred to me. Apparently the system now in effect here is sort of a voluntary one and probably comes up in connection with compulsory re-examination of drivers under certain circumstances. For instance, when there is a fatal accident, the driver, whether he is at fault or not, has to be reviewed. With the compulsory re-registration of drivers periodically you have to answer certain questions, I believe, on the application, such as whether you have epilepsy, are subject to coronary, and so forth. As a result, these things come to the attention of the commissioner more or less on a voluntary basis, or where the driver himself furnishes the information.

I think the answer probably is eventually a matter for the legislature in a statute that would set up certain requirements whereby doctors would have to report these various specified conditions without opinion as to whether or not they affect the driving, and then have a board established with the power to make recommendations with some sort of appeal provision for the driver.

You can see that this would be a serious thing for a person who must drive in order to make a living, so there must be adequate safeguards of the private interest as well as the public welfare.

You may have noticed in the paper a night or two ago an article telling of a car having gone through a wall right into a building. The caption under it was: "Police investigated and found that the driver was a 76-year-old lady who was dead." They were going to turn it over to Dr. Fisher, I think, to determine whether she died before or as a result of the accident.

I would like to drop the ball in your lap for a minute, Russ, because I heard you recently give a brief statement to us about this problem of people who die and cause an accident and those who die as a result of an accident.

DR. FISHER: I would confirm the fact that we have a real problem here. If the doctors can within their own ethics help to prevent these unnecessary accidents by helping the Department of Motor Vehicles to insure that only safe drivers are on the road, then it would seem wise to do so.

The statistics to which you referred, I think, were those that came from a survey of drivers found dead in automobiles involved in fixed-object collisions over a period of several years. Surprisingly enough, some 19 per cent of the drivers found dead after the crash in this series were found not to have had fatal injuries but to have had fatal disease. So that at least in this selected group of people who run off the road or run into fixed objects, disease accounts for the accident in nearly 20 per cent. I think this confirms the fact that we have a problem, and I think the suggestions made here tonight may stir up a little action in dealing with them.

EMERGENCY MEDICAL CALLS

Let us move on to another subject. A recent innovation in the Baltimore City Medical Society of a screening panel has caused considerable interest and comment. As you know, for a number of years the medical society has sponsored a program through Physicians' Exchange whereby any patient who did not have a family doctor and who needed a doctor in an emergency could call and he would be put in touch with a member of the panel of doctors who took these emergency calls.

This was not intended to take all calls just because a patient's doctor had gone to the movies and he couldn't be reached right away, but rather to supply doctors in emergencies when the patient did not have a family physician or could not reach his relief.

The society a year or so ago altered this program in order to lessen the burden a little bit on the panelists, the men on call, so that each member of the society acts in rotation for a twelve-hour period as a screener on these calls. That is to say, they are reported first to a doctor, not the one who might ultimately make the call but simply to one who screens the calls to decide if indeed it is an emergency situation, if indeed the patient needs a doctor to come to the home, or whether an ambulance should be dispatched.

He reaches a decision on the basis of talking with the person who calls in and advises the caller accordingly; either he will send an ambulance, or the patient doesn't need a doctor, or he should see his own doctor tomorrow, or what-have-you.

At any rate, he ends up producing advice via telephone, and this has interested us a lot. I would like to pose a question: What in your opinion is the liability of the physician who serves on this screening panel for the action he recommends?

MR. SOLTER: For those of you who are not members of the Baltimore Medical Society, in the Yellow Pages under "Physicians" there appears a little ad, if I may call it an ad. It reads as follows:

When you cannot locate your doctor, call Physicians' Exchange, PLaza 2-3340. If you cannot reach your doctor in an emergency, call Medical Service, PLaza 2-1400.

As I understand it, the last number is the one to which Dr. Fisher has just referred. First of all, as I understand it, an operator answers the call and does a little preliminary screening before she even calls the screening doctor. She then calls the doctor and fills him in briefly before he talks to the individual. So there is sort of a monitor service set up so that when the doctor does take the call, I believe the call is monitored by the operator, and perhaps—I don't know whether it is true or not, but maybe it should be done—some notes or records could be kept, over and above just the name and address and the date and the time, of just what transpired. I think this might be some sort of protection if somebody did cause trouble later.

In any event the questions to be answered are: Is a doctor needed now? Is an ambulance needed? Or is it something that you can tell them to hold until morning and go to the out-patient department or their own doctor, or find some doctor that will see them?

This is a pretty tough job, I would think, with the specializing in various fields. Frequently, when your turn is up, you might get some kind of case with symptoms that you are not familiar with, or disease you are not familiar with. You probably would refer a doctor to the case just out of good judgment or a fear that you might say the wrong thing, but in any event, this is a very difficult problem for a lawyer to answer, as to what the liability is under these circumstances.

Bear in mind we are not talking about the doctor to whom this call is eventually referred, if the screening doctor thinks a doctor should be called; we are just talking about the screening doctor.

Of course, generally, it is the duty of a physician to use the reasonable care and skill that are usually exercised by reputable physicians in the same community. That is the rule of thumb you have to follow. You have to exercise your own judgment as you see it at the time.

In researching this matter, I could find no case squarely on point. That does not say there is not one, but I was unable to find one. The closest case I could find was a New York case. Here suit was brought against a hospital and a physician for failure to treat the plaintiff's deceased husband. The plaintiff—the wife—took her husband to the hospital and informed the personnel at the desk that her husband was apparently having a heart attack. She also told the hospital personnel that they were members of some certain insurance plan. The hospital told her that they didn't handle patients under that plan. The nurse then called a doctor of the insurance plan on the phone, telling him the situation and describing the symptoms. The nurse then gave the telephone to the patient, who talked to the doctor and described his pains. The doctor told him to go home and come back when the insurance plan clinic was open. The patient died during the night.

The trial court dismissed the complaint against both the hospital and the doctor, but the Court of Appeals of New York took care of the situation and reversed, holding that a prima facie case had been established against both the hospital and the doctor and said that a doctor who undertakes to examine or treat a patient and then abandons him may be held liable for malpractice.

Actually I think that applies a little bit more to the second step in your procedure, but there it is for what it is worth. You would, I think, have to be extremely careful in using your judgment in these matters.

The fact that this is a gratuitous service doesn't relieve you from liability if you in fact are negligent under the definition which I have just given a few minutes ago. Having once undertaken to offer the service, the doctor must exercise that reasonable care and judgment that is accepted in the community in his advice.

I was asked whether I thought that the association as a group or as a unit would have any liability in a case of a doctor who negligently carried out this service. It was my opinion that the association probably would be exempted from liability because of its character and the fact that it is a non-profit organization which is rendering this service as a public service. But I am sure that could be debated quite extensively.

Of course, if the doctor is called as a result of the screening service, he must then go ahead and take the case and follow through to a reasonable conclusion until the patient is in the hands of someone who is competent.

I would like to say this at this juncture, before I close on this point, that I think there is a lot of fear of malpractice suits and liability on the part of doctors that is unjustified. It has been exaggerated because of the facts you see in the unusual case. I would like to read to you from one of the recent Maryland decisions what the plaintiff has to prove in a malpractice case in order to recover against you if you should be sued. This is a quote from *Suburban Hospital Association Incorporated v. Mewhinney.*

> It is settled in Maryland that the burden of proof in a malpractice case is upon the plaintiff to show a lack of the requisite skill or care on the part of the physician and that such want of skill or care was a direct cause of the injury; proof of either of these is wanting, the case is not a proper one for submission to the jury . . . General rules of negligence apply to malpractice cases as well as to ordinary claims of negligence. Therefore, to constitute actionable negligence, there must be not only causal connection between the negligence complained of and the injury suffered, but the connection must be by the natural and unbroken sequence without intervening efficient causes so that, but for the negligence of the defendant the injury would not have occurred. It must not only be a cause, it must be the proximate cause.

That is a stiff burden of proof for those of us who are in the area of negligence trial work, and I submit to you that it is a most difficult one to meet. Proof of that is that in the Maryland reports you will find that most malpractice cases that go to the higher courts end up—if they didn't end up below in favor of the defendant—in favor of the defendant, the physician, and the hospital.

LAWYER-DOCTOR LIAISON IN TRIAL WORK

DR. FISHER: We have one other question to be discussed here this evening. I am going to start by asking Mr. Israelson to discuss it and to round off the program by giving Mr. Solter a turn at it also.

There are frequent problems in communication between doctors and lawyers. Would you like to list several of these and suggest at least one method of dealing with each in the interest of better communication between the two professions?

MR. ISRAELSON: In approaching this, I selected what I think are probably four of the outstanding problems and approached it with the hope that in defining them, in discussing them, it may tend to draw our two professions closer together, help each to understand the other's problem, and possibly work a little more to eliminate them as problems.

The two professions meet most frquently in the personal injury field. You have two groups of physicians: the physician who has made up his mind he will accept these cases and will cooperate in their handling and the physician who will not. The first problem that arises is that of reporting on the case. Either a doctor is set up by inclination and secretarially to handle this or he is not.

If he is set up to handle them, then he should cooperate in reporting to the attorney on proper request. It is helpful, as you all by now have learned by the request of the attorneys, to report with several copies, because your report is not secreted in the lawyer's file—not under our present practice. Our present practice in the last twenty some years has been led by Chief Judge Emory Niles. Judge Niles' thorough administration of these discovery procedures has brought out of the darkness and eliminated surprise elements in the trial of cases by these procedures, which let both sides know what is in the other side's file. This means not only witnesses in the case but, from your viewpoint, the medical reporting of the case. So, when your report is received, if you are to testify in the trial of the case, a copy of your report must go to the other side in response to a proper interrogatory. Therefore, it helps immeasurably if you send your report in triplicate or duplicate, along with your bill, similarly in duplicate or triplicate.

If the doctors understand that everything stops in the negotiation and processing of a personal injury claim until their report is received and appreciate that this puts an absolute brake on the process of handling the claim, helping the patient

spring 1966

DORSEY Season

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Duodenal mucosa with ulcer crater—
Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

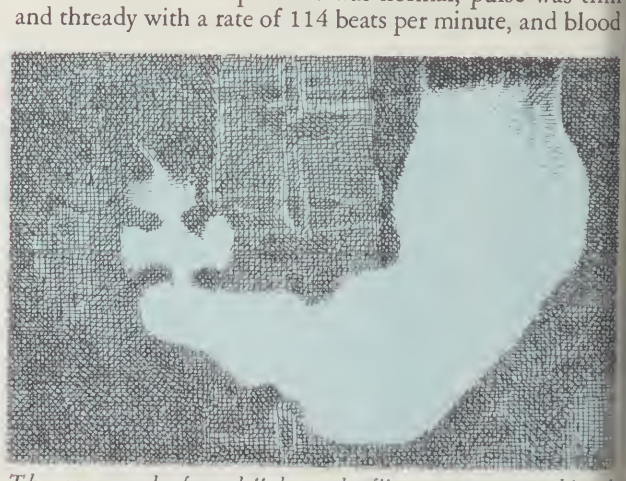
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

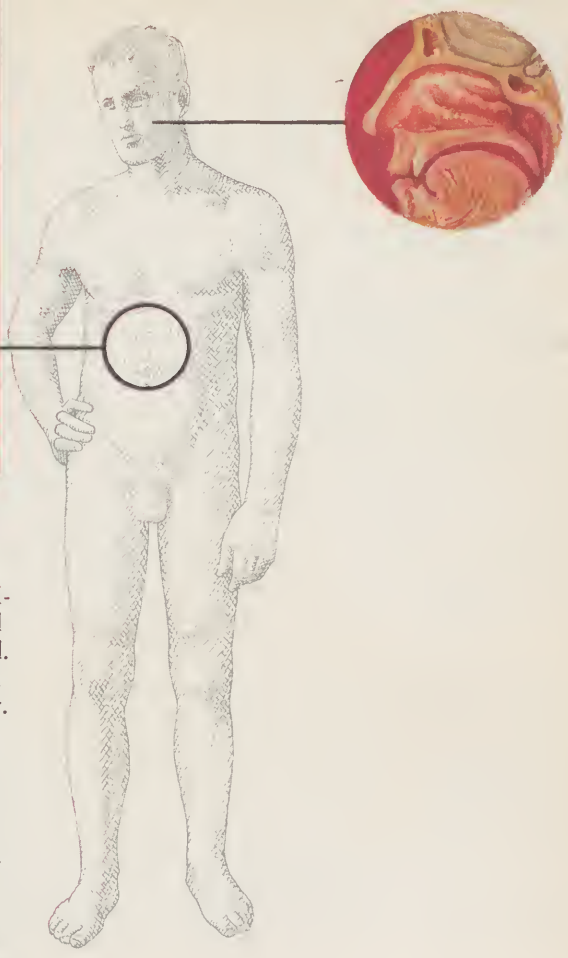
The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.





Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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(Advertisement)



substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

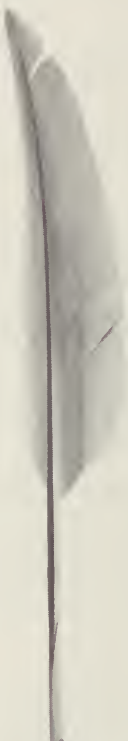
Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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conclude his claim, and payment of the doctor's bill, they would honor the request for reports as quickly as they can.

Reporting in these cases is just as much an obligation of the doctor who accepts the treatment and handling of it as the treatment itself. The doctor should never, of course, exaggerate or misstate his findings, his appraisal or his prognosis, any more than any other report should be exaggerated.

As to those who don't handle these cases, I lament their decision, and I have a feeling that Judge Niles would agree that those doctors who rid themselves of the problem by saying, "I just won't handle this kind of case," are really depriving both the patient and the judicial processes of some of the most competent and able advice in the medical field.

The next problem is what bothers you doctors so much: court attendance. The doctor's quite valid objection is the wasting of his time, but both the doctor and the lawyer can cooperate much more fully in this sphere toward eliminating this as fully as possible—you will never eliminate it completely—under the terrible situation in which the legal profession finds itself today.

For a combination of reasons, which committees of the Supreme Bench and the Bar Association are trying to fathom and correct locally, there is a serious backlog of cases, and I am sure all of you have heard or read of the backlog in most of the courthouses of the metropolitan areas in the country.

In one assignment, 209 cases were marked in the final assignment for one day, allegedly ready for trial with four civil judges operating the courts the following day. That is the unusual, and it is no use talking about the unusual or exceptional. Let's hope that this is a temporary situation and that it will revert to the former situation when cases could come up and be tried in normal course.

Here is the procedure followed in the courthouse in this city in connection with most of the personal injury cases. Three weeks before a case is tentatively scheduled for trial, the assignment commissioner sends out a postcard to the lawyers on both sides. Keeping in mind that at the optimum we have six civil trial judges in jury cases operating in our courthouse at any one time, you may wonder why the assignment commissioner sends out 100 cards—100 cases for a specific day three weeks hence.

I think you will find the answer rather obvious. In the course of three weeks many cases are settled; many are postponed for various reasons; and what we are trying to do is line up with enough cases, maybe just a few more, so that the six courts will be kept busy. When we speak of being kept busy, this means busy throughout a trial day, because you have to have a small backlog in case one of the assigned cases on that day is settled at the last minute or postponed at the last minute, and the judges, wanting to keep busy, want another case ready to go.

Of course, there is a multitude of reasons for postponements. Some of them are real; some of them are not so real. But many of them center around the absence of a witness, the absence of the client, the illness of a lawyer, the absence of a doctor, and many, many other reasons.

Nevertheless, the doctor's complaints are that he is notified to get ready; he puts time aside; he even cancels out office hours or eliminates some patients who are by set appointment. Then at the last minute he is called and told that the case is settled or postponed; in any event it is not going ahead.

He also complains: "I get a summons, I come to court, and that morning, after I have gotten to court, I am told the case is settled or postponed." The last complaint is when the case goes ahead, the doctor comes to court, but he is kept waiting.

These are valid complaints. To those in my profession, I lay at our feet a great part of the responsibility for this. It should be kept in mind, however, that the three-week notice is by no means more than a tentative notice, and it is utterly impossible for the court, for the judges, for the assignment commissioner, or for the lawyers to know with any reasonable degree of certainty until one day before the trial that a case is or is not going ahead.

When that takes place, after letting the doctor know tentatively a couple weeks in advance, the day before the trial is the first day of real activity. A call ought to go from the lawyer to the doctor or his secretary, telling him, "The case is in third or fourth position after the pending case. We may start tomorrow, doctor. I am sorry, that is the best we can tell you right now."

At least alert the doctor. It is not definite, but it is a maybe. We know that doctors have difficult schedules. If the lawyer checks with the lawyer in the pending court case to arrive at some estimate of the likely termination hour of that case, and then takes into consideration the one or two other cases ahead of him, he may be able to say to the doctor the day before, "I think we will get started tomorrow afternoon, in which case, doctor, we can't use you until day after tomorrow, because the opening hours will be taken with jury selection, opening statement, factual witnesses, and so forth."

On the eve of trial, and still better at ten o'clock the next morning, when the final assignment of cases is made, the lawyer is in better position to say to the doctor, "We think we will be able to call you between one and two o'clock tomorrow."

I think this gives the doctor some assurance that he need not sit by for any part of the whole first day and then look for another call the end of that first day for a fairly definite hour on the second day of trial.

One thing the doctors seem to resent is the issuance of a summons directing them to be in court at ten o'clock the next morning. You get a summons because the attorney must send you a summons. If he does not, and if he relies on merely telephoning and having you come in at the proper time, he lays himself open to severe censure from the judge if the case is on and the doctor is not there. The lawyer will very likely be asked, "Have you summoned the doctor?" If he dares admit he has not, the judge will direct him to proceed without the doctor, without the proof of injury, without the doctor's appraisal of permanency, without even the doctor's bill.

Some of the doctors ask, "Why can't my report be used instead of my coming to court?" Your report, excellent as it may be, detailed as it may be, does not contain all you will talk about in court. Still more important is the proposition that a report is not subject to cross-examination. You are. The opponent in the case has an absolute right to ask you questions, to try to qualify your opinions, to try to explain your findings and so forth, so that except in the very rare case that opposing counsel can stipulate, a report cannot be used.

When the doctor appears in court, the attorney asks, and usually the court will grant permission, to remove the witness on the stand, take the doctor out of turn, permit him to complete his testimony, and then excuse him promptly. If a judge does not do this, there is usually a good reason for it.

The third big problem has already been touched on by Mr. Solter, and that is the problem of malpractice. I agree with him, although we are frequently found on opposing sides of the trial table, that malpractice is exaggerated greatly, particularly here in Maryland. The newspapers and publications and reports out of California headlining the tremendous verdicts they get out there —none of which, incidentally, have ever been gotten in Maryland—is quite natural to rouse in the doctor some fear. The fear goes not only to his pocketbook but it goes to his ego. It goes to his professional reputation, so I don't blame the doctors for having the fear of it, but I would like to give you a few of the statistics I have been able to elicit. Unfortunately the State Insurance Department and the insurance companies do not segregate the statistics having to do with malpractice claims and payments as well as we might want; they are rather fragmentary.

This report was filed in December, 1962, with the State Insurance Department of Maryland. It is made by all companies reporting to the National Bureau of Casualty Underwriters. This includes approximately 150 out of 200 companies that report to the National Bureau. At the same time we ought to realize there are only four or five companies doing any appreciable business in Maryland.

Here are the statistics, which, unfortunately, while filed in December, 1962, are somewhat belated in that they refer to the five years preceding; 1955, '56, '57, '58 and '59. They are the latest reports we are able to find. In 1955 there were 24 claims; in 1956, 20 claims; in 1957, 25 claims; in 1958, 31 claims; in 1959, 35 claims. I am willing to assume there has been some increase in each of the next couple of years.

I spoke about this with an attorney of top standing in our community who has had some experience in this, and he felt—and I am inclined to agree with him—these sound like very low figures. However they are as complete and accurate as obtainable.

In that five-year period, based on the premiums taken in by all these companies reporting, com-

panies which did business in Maryland, the earned premiums for the entire period were $638,-668. The incurred losses were $321,061, meaning there is a loss ratio in the entire five-year period from 1955 to 1959 inclusive of 50.3 per cent.

That is not a strictly fair figure to the insurance company because in between earned premiums and losses incurred are the underwriting costs and the costs of doing business.

On the other hand, this statistic shows incurred losses, not paid losses, so that again there is an accounting difference there, it being, I believe, correct that the paid losses usually are below the reserves they put aside for what they call incurred losses.

This is the latest report available. It is my understanding that insurance rates are supposed to be geared to the loss ratio experience in the state of Maryland. I am confident that your society checks this carefully. In my best judgment, it would not be equitable if Maryland doctors are paying premiums based on *national* experience, because we know that many states around the country have much higher losses.

I am informed on good authority that at least one of our four major companies writing in Maryland is about to *decrease* its premium on malpractice insurance, which again would be an indication of the trend. If one does it, the four others are likely to follow suit.

So this bogey man that has been conjured up to scare the doctors and to alienate their affections for lawyers is not quite so big and dangerous a fellow as the exaggerated headlines might have us believe.

There is one other element of liaison where I think we could be on better ground. This has to do with the payment of doctors' bills. This is an inexcusable negligence on the part of attorneys, and I see a good many of my friends who are counselors in the audience. I say to you, if nothing else, I have two suggestions. I will get right to the meat of it.

In your power of attorney with your client, if you insert this, which I have incorporated into mine: "I further agree to be responsible for all depositions, medical, hospital, and other expenses as are necessary, and authorize my attorney to pay any that are unpaid out of my share of any recovery," that goes halfway, because this authorizes the attorney to pay them.

There is one more form I recommend to the lawyers, and I would recommend it to the doctors:

Dear Doctor, I retained Attorney So-and-so to handle my claim for injuries occurring (date). Kindly furnish him with such information and reports as may be requested of you concerning my physical condition or treatments given both before and since said injuries. I agree that I am personally responsible for all charges incurred for examination, treatment and/or reports, and should there be unpaid charges for these or other professional services due by me or my family owing at such time as any sums are recovered by my lawyer, he is authorized and directed to pay such unpaid charges in full out of my share of any recovery.

That would go three-fourths of the way. One more protection that the doctors can insist on if they care to, is to say; "I will be delighted to send you my reports, but, Mr. Attorney, please sign this last paragraph:"

I agree to comply with the authorization and direction of my client and pay the bills rendered by you in full out of any recovery to be obtained for said patient or his family.

Have the lawyer sign it, and you have a binding claim. I don't think any lawyer of repute would fail to pay a doctor's bill.

DR. FISHER: I am going to ask Dr. Classen and Dr. Ward to pick up any questions that may be written. While they are doing that, making a brief screening of these questions, I would like to ask Mr. Solter if he would like to comment on this general field of doctor-lawyer liaison.

MR. SOLTER: I certainly would like to comment on it, because I think that something has got to be done by both professions to erase the image as far as the lawyer is concerned of the demanding, selfish, inconsiderate person who is trying to use the doctor in order to make a big recovery and therefore a big fee, and the image of the doctor, on the other hand, of the prima donna who can't take time to follow his case to the logical conclusion that his association with the patient demands under certain circumstances.

I think that the two images are created by a small segment of both professions, but, as is always the case, the problem rubs off on everybody. The result is that you have unhealthy and unfriendly relationships existing.

I would hope that some day a president of the Bar Association of Baltimore City or the Maryland State Bar, or both, and the president of your society would form a joint committee to look into this problem, because I think it is extremely damaging to us both in the eyes of the public. Believe me, it is just as difficult from our side

as it is from yours, and I think the real answer to it is a simple one basically, and that is the use of common courtesy.

It is just as discourteous to a considerate lawyer to call up a doctor and ask him about a court appearance and get on the other end of the phone: "Who do you think you are? I'm not going to court. I don't testify and, furthermore, if you don't like it, you know what you can do about it." That happens, believe me. The only thing to do is issue a summons for him, and if he doesn't come in, ask for a bench warrant or appropriate summons. By the time he gets in, if you have to use him, he has lost his effectiveness because he is so mad that it rubs off on his testimony, and the whole thing turns into a great big fiasco.

I appreciate also the problem of the doctor who, without any prior notice, suddenly has a sheriff hand him a summons, particularly if he is one of the doctors who doesn't get into the situation often. The oldtimers who are used to it know how to handle the problem, but I have had clients of mine who are doctors call me up in a panic and say they have a summons for ten o'clock tomorrow morning. "I have got six operations set, an office full of patients, and so forth and so on; what am I going to do?" I won't tell you what my advice to them is, but it can easily be worked out.

I hope that this whole area can some day be explored and some helpful rules of mutual conduct developed that will make it easier for us, make it better for our patients and clients, and easier for the courts to cope with as well.

DR. FISHER: Here is a question directed to Mr. Israelson: What duty does the attorney have to pay an adverse medical witness that attorney may have to summons to court?

MR. ISRAELSON: When an insurance company requests an examination of the client, I permit it voluntarily without their having to get an order of court. If the report is reasonsably favorable, the attorney must ascertain if the opposing attorney is going to call the doctor to court. In one case I handled, although the opposing attorney said he was going to call the doctor to testify and indicated to the judge that he would, he failed to do so. So I summoned him. He then sent a bill for his testimony. I took the position that he had been called for examination by the opposing side; he had been paid by the opposing side, and should be paid for any court attendance made necessary by his examination.

DR. FISHER: Mr. Solter has two which I think are related to the problem of the Good Samaritan.

MR. SOLTER: These two questions overlap. What about a physician not licensed to practice in Maryland who in passing through Maryland encounters an injured individual? Is he protected according to Maryland law?

The other question is the other side of it: Is a Maryland doctor protected by the Maryland act if traveling in another state and renders aid and is later sued in Maryland?

This points up the problem I mentioned in the beginning. I would have to say, in answer to the first question, "Is a non-resident doctor protected in Maryland under the Maryland act?" the answer is no. The law specifically says a physician licensed to practice by the Board of Medical Examiners of the State of Maryland.

As to the second question, I would have to say no to that also, that the doctor from Maryland who is traveling elsewhere is not protected by the Maryland statute, but there might be more likelihood of that than otherwise if there is some comity between the states involved. This is not a reciprocal sort of statute in its present form, and I think these two questions clearly point up the need, if you are going to have the statute at all, to have it a uniform statute adopted in all states in the same language.

Of course, that is a rather rough problem, but it has been done in many areas of the law and maybe some day a Good Samaritan will be a Good Samaritan, whether he is in Baltimore or San Francisco.

DR. FISHER: One further question along that same line: What is civil negligence as applied to the Good Samaritan Act?

MR. SOLTER: That would be what I pointed out earlier in my notes here. It is a failure on the part of the doctor to exercise that degree of care, or a reasonable degree of care and skill that is customarily exercised by reputable physicians in the same area. Basically it is using that accepted standard of medical procedure which is customary in the community in which you are practicing. If you don't use that, then you have at least from a prima facie standpoint been guilty of an act or omission constituting ordinary negligence in the concept of a medical malpractice case.

DR. FISHER: As distinguished from criminal negligence in which there must be gross and wanton disregard for the life or property of another.

MR. SOLTER: I don't exactly agree that it would be necessarily criminal negligence used in the context of the Good Samaritan Act. We usually think of criminal gross negligence as having some sort of a penal aspect to it, but I don't think there is any penalty involved here except that of responding substantially in civil damages at the hands of a jury.

DR. FISHER: Here is a question which I believe will preempt my legal brethren from answering. Should out-patient mental patients who are under heavy sedation be allowed to drive?

This is a medical question, but I think any one of you here could answer it equally well, that any patient under heavy sedation has no business driving an automobile. Whether it be alcohol or drug sedation, he is a hazard on the highway, and he should be kept from driving in the interest of his own life as well as that of his fellow drivers.

Mr. Israelson has one with regard to some of the material he discussed. Is there any statutory authority for the action you set forth for the Department of Motor Vehicles as far as revocation of license is concerned?

MR. ISRAELSON: Yes, there is a statutory authority in the regulation given—the powers given to the Department of Motor Vehicles to regulate the safe driving on the highway. Under that they have set up this medical examining board that I have mentioned earlier. The reviewers and license examiners and those in authority then, upon recommendation of that board, have a complete right to revoke that license.

The question really went on: Does the person whose license is so revoked have appeal to the courts, and does prior good record enter into consideration? Yes, there is an appeal; any decision of the Department of Motor Vehicles revoking a license is appealable.

DR. FISHER: Here is a brief one: It it necessary to testify in court without proper arrangements for payment of services being made prior to trial? If so, how can payment be assured?

While you are cogitating about that, I am going to read one which is obviously a statement not a question, but you may enjoy it: "I wish to bring your attention to how inconsiderate some attorneys are in summonsing a doctor the day before trial, when the summons is the first notice the doctor has had of a case coming to trial, for instance, of a patient he examined many months ago."

I think we will get a comment from both members of the panel with respect to the question about pre-arrangement of service or fees before the trial and how a doctor is assured he is going to get paid later.

MR. ISRAELSON: There are two classifications, as I understand it, having to do with payment to physicians for testifying in court, one with regard to the so-called expert witness—that is, the witness called in to give an expert opinion—as opposed to merely his treatment of the patient and the factual medical details. Either can insist on payment. The nice way and proper way to accomplish this would be to call the attorney and say, "Now, you have asked me to come to court; my time is valuable; I would like some assurance of payment."

I am glad to say that most attorneys will cooperate on this. A doctor will set a reasonable fee; the lawyer will consult with the client and see if he is willing to assume this; that is, without contingency, because the doctor's fee is not on a contingency basis. The lawyer is nearly always on a contingent basis, so the lawyer runs a risk of not getting any fee.

Either the client-patient or the attorney can assure the doctor of payment if he chooses to do so. In any event, and especially in the cases in which there is a recovery, the payment for court attendance in my humble judgment is just as binding on the attorney to deduct from the recovery as is the bill for services for treatment.

MR. SOLTER: I have nothing to add to that. Is a medical student from out of state without a license to practice in Maryland covered by the Good Samaritan Act? The answer is no, because he is not licensed to practice by the Board of Medical Examiners of the State of Maryland, which is specifically set forth in this statute. This points out the complaint that many people have about the statute generally, that it should say "Any person who gives medical aid should be protected," because now it is giving the doctor greater protection than a layman or perhaps a person like this medical student who may be just

about ready to take his boards and really knows what he is doing.

The next question which has been handed me is: What is the law pertaining to attorneys referring clients to physicians? Are they practicing medicine when they do this?

I don't know exactly what is meant here, whether the question is when your client manages to pull himself into your office before having gone to a doctor, and then you send him to a doctor, or whether it means when you have a medical-legal problem in the course of preparation of a personal injury case and you refer him to a specialist for an examination and a report. Certainly the latter would in no sense be improper in any way I can think of.

The other, I must say I don't know the answer. I don't think the lawyer is practicing medicine, of course, but there may be some ethical point involved. I would think that if the lawyer, in his judgment, felt that the client needed help because he didn't know a doctor or had no way of getting medical advice and had some ostensible signs of injury, he would be entitled to suggest a doctor for him to see. I think the converse of the problem usually comes up more frequently, about doctors referring patients to lawyers, but I won't comment further on that.

MR. ISRAELSON: May I say just one word on that? There is no impropriety whatsoever for an attorney in the course of handling a case to get in touch with the treating doctor and ask certain information which may call for a specialist's opinion. It would be better from protocol to ask the treating physician to refer him to a specialist, but if the treating physician indicates he has no choice of a specialist and the attorney wants to suggest or recommend a reputable specialist, there is no impropriety whatsoever.

I cannot understand why lawyers shudder in court when the opposing counsel asks: "Were you sent to the doctor by the plaintiff's lawyer?" The plaintiff's lawyer should tell this in the opening statement to the jury: at some point in this case a question came up as to whether Mr. Jones had a certain condition. I called Dr. Smith and asked him to give me his opinion. As a matter of fact, frequently we call in a physician for private consultation, for the attorney's own information, to ascertain the real condition of the client.

DR. FISHER: There is a brief question here to outline the procedure or procedures to be taken in advance by an attorney to prevent the doctor from losing precious time at the trial by being forced to await his turn to testify.

MR. ISRAELSON: I mentioned that in the course of the main discussion, but when the attorney suspects he may have any difficulty with the judge, he should go to the judge in advance, before the case starts or at some juncture in the case when he is at the bench, and merely say, "Your Honor, I expect Dr. So-and-so in here at eleven o'clock. I know it will be taking him out of turn, but would you permit me to do this?" He may consult the other attorney; the other attorney may or may not object. Then it is entirely up to the court.

DR. FISHER: I'm going to ask Mr. Solter to answer a brief one, again about the Good Samaritan Act, comparing it in this state with other states, on the basis of the fact that our act specifies acts of the doctor without fee shall not be subject to litigation.

MR. SOLTER: Our act says, "For which the physician receives no fee or compensation." The question was asked: Our Good Samaritan Act contains the statement, "To a doctor who does not receive a fee." Is this statement or phrase in the acts of other states? If not, does this make the Maryland law different.?

Just shuffling through the other statutes here I see some of them do and some of them don't. Georgia said, "Without making any charge." There was another one that used the word "gratuitously." Then I ran across this one which answers one of the previous questions. This is the North Dakota statute. Specifically it extends the benefits of this statute to any physician or surgeon duly licensed to practice his profession in any other state.

They all vary. They all have different terms. I just wonder how much of a problem this really is to a doctor under those circumstances.

DR. FISHER: I would like to express the appreciation of the committee for the attendance of my two counselors, who have certainly done a very excellent job this evening. I would like to express the gratitude of the committee to those of you who came out on this threatening night which turned out to be one whale of a rainy night to join us.

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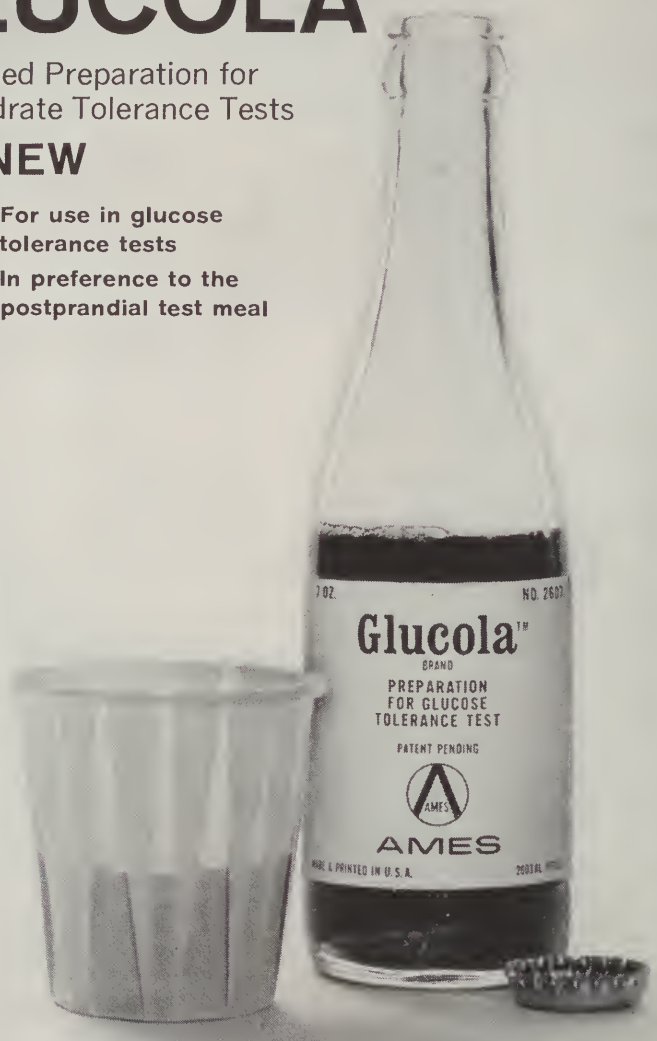
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AMES

History of the Baltimore City Hospitals

BY DOUGLAS CARROLL, M.D.



Chapter 5.—The Almshouse At Calverton: The Beginning of Scientific Medicine (1840-1865)

It would be impossible to tell in detail how Louis' students brought back his spirit and his methods to their daily work, and of the revolution which they gradually effected in the study and in the treatment of disease.

Partly because the time was ripe and they were active agents in bringing the new art and science to the New World, partly owing to inherent capabilities, etc., but not a little because the brightest minds among them fell under the influence of Louis—they more than any others gave an impetus, which it still feels, to the scientific study of medicine in the United States.[1]



Advances In the Science of Medicine

If a time had to be set for the introduction of scientific medicine into the City of Baltimore, the year would be 1840; the place, the Baltimore City and County Almshouse; and the person, Dr. William Power. For it was in Dr. Power that the new age of scientific medicine was personified and brought to Baltimore.

Born in Baltimore in 1813, Power graduated from Yale in 1832 and from the University of Maryland School of Medicine in 1835. He was a student at the Almshouse in 1834. He then went to Paris to study five years with Pierre Louis. He was one of a number of Americans who brought back Louis' spirit and methods to the United States. As resident physician at Calverton in 1840, he introduced careful medical history, the new methods of percussion and auscultation in the physical examination, proper progress notes, and careful postmortem examination to try to understand the nature of disease. He

Fig. 1

William Power (1813-1852): AB, Yale (1832), MD, University of Maryland (1835), student of Pierre Charles Alexandre Louis at Paris from 1835-1840. Resident physician, Baltimore Almshouse 1840, attending physician, 1841-1852, professor of practice of medicine, University of Maryland School of Medicine. (Collection of Medical and Chirurgical Faculty of Maryland.)



Fig 2

Thomas Hepburn Buckler (1812-1901): MD, University of Maryland, 1835. Physician to Baltimore City Almshouse 1840-44 and 1946-50. Author of "History of Epidemic of Cholera at Baltimore Almshouse," 1851. (Collection of Medical and Chirurgical Faculty of Maryland.)



Fig 3

Staffordshire dark blue china teapot. "Baltimore Almshouse" From Moore, N. Hudson: "The Old China Book," Tudor Publishing Co., New York 1903 (Reprinted 1937, see p. 76). Picture of Almshouse is copy of Latrobe's "Alms House, Calverton."

continued his interest until 1852, when he died at the age of 39.

Characteristic of this period were the scientific papers resulting from work performed at the Almshouse. Dr. Thomas H. Buckler wrote his interesting book on the cholera epidemic.[2] William P. Howard carefully studied patients with malaria.[3] Articles on other infectious diseases were published.[4]

All through this period, medical students, residents, and visiting men participated in a teaching program as well as in patient care. Clinical lectures by the visiting physicians were frequent.

A number of students and residents at the Almshouse later became professors at the University of Maryland: Christopher Johnston in surgery in 1869; Frank Donaldson in physiology and hygiene in 1866; George Warner Miltenberger in obstetrics in 1858, and William T. Howard in diseases of women and children in 1867.

A large vegetable garden and dairy herd helped supply food for the inmates. There was a shoemaker shop, a tailor shop, a tin shop, a barber shop, a blacksmith shop, and a children's schoolroom. In 1865, 1,615 people were admitted; 57 children were born in the institution; 1063 were discharged; and 174 died. About 45% of the people admitted were of foreign birth. The largest number of admissions was in the age group 20-30 years. No residence requirements were necessary for admission. Nearly half the people admitted were thought to be "intemperate." The most common diagnoses made in 1865 were: debility, gonorrhea, primary syphilis, secondary syphilis, ulcers, acute and chronic rheumatism and phthisis pulmonalis.[5]

Attitudes Toward Inmates of the Almshouse

Segregation of the races was definitely being enforced at the Almshouse as early as 1818 and continued into the 20th century. Slaves were not admitted.

During the cholera epidemic in the Almshouse, two leading men of Baltimore, James McHenry, "a gentleman of fortune," and John C. Brune, not only volunteered their personal services as nurses but also give money to help the sufferers.

Perhaps much of the reforming zeal of this period was being used in the improvement in public education. In Baltimore, at least, there was no major loss of humanitarian energy in the abolition struggle.

In his book on cholera at the Almshouse, Dr. Buckler in 1851 noted that a single attack of illness often consigned an individual to the doom of pauperism. He stated that the first duty of every community is to take care of the poor and ignorant because they are unable to take care of themselves. This view echoes Chrysostom's wholly Christian point of view: "The poor have only on recommendation: Their need. If he be the most perverse of all men—should he lack necessary food, we ought to appease his hunger."[6]

In October, 1866, because of gradual deterioration of the building and the unhealthy situation, the Calverton Almshouse property was sold for $341,000, and the move to the present location was carried out.

Calverton had been unfortunately located in a mosquito-infested swamp. It was prone to epidemics of all the infectious and mosquito-borne diseases. In the midst of ignorance, epidemics, and filth, the beginnings of scientific medicine were laid by Dr. William Power.

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ALLEGANY COUNTY

NEW 1966 OFFICERS

On December 15, the following officers were elected to serve for 1966: **David H. Miller, MD,** president; **L. Michael Glick, MD,** vice president; **Lester Kiefer, MD,** secretary; and **Wyand F. Doerner, MD,** treasurer. The Society has planned an active program for 1966, which includes outside speakers, joint meetings with the Pharmacists' and Bar Associations, and several social functions.

NEW PROFESSIONAL PERSONNEL COME TO ALLEGANY COUNTY

In June, 1965, **G. Allen Moulton, MD,** joined **Lester Kiefer, MD,** pathologist and director of laboratories at the Memorial Hospital, to serve as pathologist. Dr. Moulton is a graduate of The Johns Hopkins University School of Medicine. He was formerly associated with the Department of Neuropathology at the University of Maryland School of Medicine under the auspices of the National Institute of Neurological Diseases and Blindness, National Institutes of Health.



Allegany County Medical Society Officers, left to right: Lester Kiefer, MD, secretary; David H. Miller, MD, president; L. Michael Glick, MD, vice president; and Wyand F. Doerner, MD, treasurer.

In July, **Wayne C. Spiggle, MD,** joined **L. Michael Glick, MD,** in the private practice of internal medicine. Dr. Spiggle is a graduate of the Medical College of Richmond, Va., 1961. He completed his training in internal medicine at the West Virginia Medical Center, in Morgantown, with a subspecialty in clinical hematology.

In September, **Robert F. Miller, MD,** joined the Department of Radiology of the Memorial Hospital as associate radiologist. Dr. Miller received his training in radiology at the Germantown Hospital in Philadelphia. He became a Diplomate of the American Board of Radiology in 1964. Before his present position, he was radiologist at the Keesler Air Force Base Hospital, Biloxi, Miss.

In October, Kenneth N. Takehara, PhD, joined the laboratory staff of the Memorial Hospital as clinical biochemist and associate director of labo-

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ratories. Dr. Takehara received his PhD in biochemistry from the State University of Iowa in 1953. Before joining Memorial Hospital Laboratory, he was assistant laboratory director and clinical biochemist at the Conemough Valley Memorial Hospital, Johnstown, Pa., from 1953 through 1965. He also was consultant to the district attorney for three counties in Pennsylvania in problems referable to forensic medicine. He had published an article on marihuana in 1964.

PERSONALS

In October, **A. J. Mirkin, MD,** Cumberland, presented a paper on "Medical Aspects of Automotive Safety" before the joint meeting of the Indiana State Medical Society and the Congress on Environmental Health. Later, he represented the American Medical Association at a meeting of the Canadian Medical Association, speaking on medical aspects of traffic accidents.

On February 12, approximately 100 members of the society enjoyed a dinner-dance at the Cumberland Country Club.

On December 8, **Dr. and Mrs. Thomas F. Lewis,** Cumberland, became parents of their sixth boy.

On February 25, **L. Louis Mould, MD,** Cumberland, fractured his right tibia and fibula while skiing in western Pennsylvania.

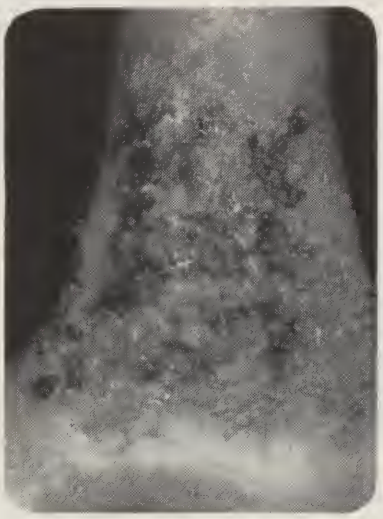
Leslie E. Daugherty, MD



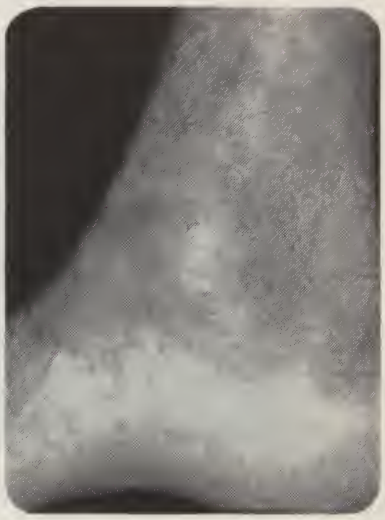
BALTIMORE CITY

The scientific session on Friday, March 4, was presented by **C. Lockard Conley, MD,** professor of medicine, The Johns Hopkins University School of Medicine; **Dudley P. Jackson, MD,** associate professor of medicine, The Johns Hopkins University School of Medicine; **R. Patterson Rus-**

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sell, MD, instructor in medicine, The Johns Hopkins School of Medicine; and **Samuel Charache, MD,** fellow in medicine, The Johns Hopkins School of Medicine. The subject of the panel discussion was polycythemia and related disorders.

Dr. Conley said that the term *polycythemia* means an elevated hemoglobin content and hematocrit in the circulating blood but that a high hematocrit alone is not necessarily a part of the definition. Dehydration and diuretics may reduce the plasma volume and produce a falsely elevated hematocrit. The clinical manifestations of polycythemia are the result of the increase in blood volume and in its viscosity. The clinical manifestations are florid appearance of the face, changes in the vascular system with a tendency to disease of all blood vessels, primarily manifested by insufficiency and thrombus formation. The primary cause of polycythemia is arterial oxygen unsaturation which leads to the formation of erythropoietin in the juxtaglomerular apparatus of the kidney. Anoxia is the stimulus for this production. Causes are hypoventilation, the so-called Pickwickian syndrome, high altitude living, arteriovenous fistula, diseases of the lungs and heart which lead to an effective right to left shunt, abnormality of hemoglobin impairing the transfer of oxygen such as methemoglobinemia and an inherited hemoglobinopathy recently discovered and named Chesapeake Hgb, which has high affinity for oxygen. Administration of testosterone and the overproduction of corticosteroids such as in Cushing's disease may be associated with polycythemia. Finally, exposure to cobalt salts, which stimulate erythropoietin production, may cause polycythemia.

Dr. Jackson described polycythemia vera as a condition in which there is elevation of the hematocrit, the white blood corpuscles, and the platelets, accompanied by splenomegaly. Occasionally, the leukocyte count may not be elevated. Dr. Jackson reported on a patient who had conjunctival suffusion, nasal congestion, an hematocrit of 73, and was found to have a mass in the left upper quadrant of the abdomen. He was operated on and was found to have a hypernephroma. Dr. Jackson reviewed the incidence of polycythemia in association with hypernephroma. There is an incidence of polycythemia with nephroma. In such patients the plasma contains measurable erythropoietin, which the kidney produces. The





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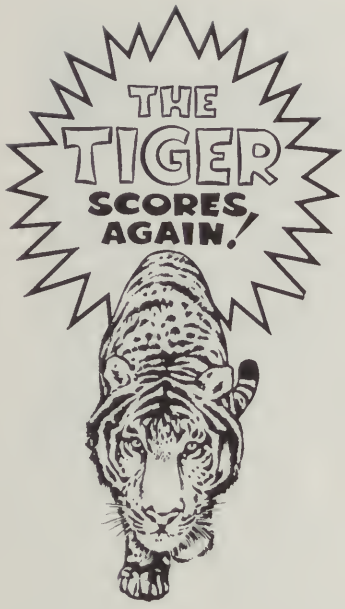
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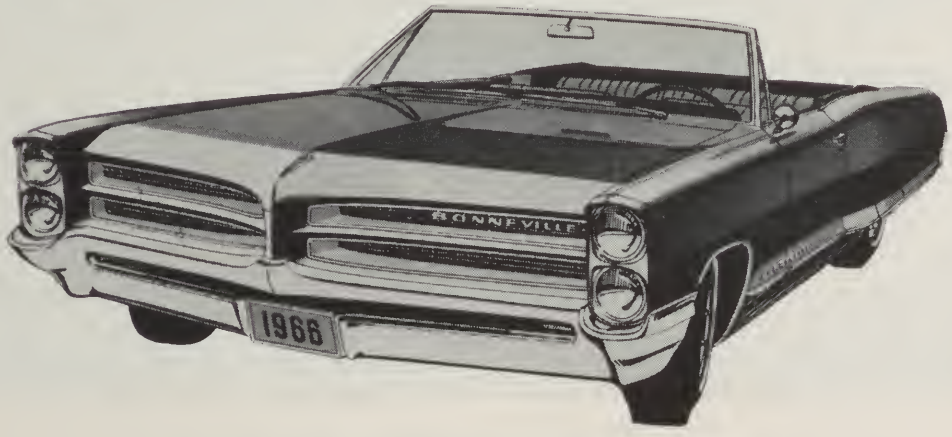
erythropoietin disappears with removal of the tumor and reappears when metastases from the hypernephroma occur. This has been seen also in renal carcinoma, adenomas, and sarcomas of the kidney, in renal cysts and renal tuberculosis, and in nephrosis, as well as in association with tumors of the brain, liver, adrenal, and uterus.

Dr. Russell described a group of patients who had elevated hematocrits without apparent cause. They were found not to have renal tumors, and there were no definitive causes (such as Dr. Conley outlined) of polycythemia associated with their illness. The inpatients were all men around 45 years of age who complained of dizziness and headache. Many had previous myocardial infarctions and history of gastric or duodenal ulcers. They all smoked fairly heavily, had histories of hypertension in the family, and exhibited other manifestations of vascular disease. On physical examination they all had hypertension and were generally of a stocky build and overweight. For the most part they exhibited only a rise in hematocrit but had normal leukocyte counts, normal platelets counts, normal differentials, and no splenomegaly. The patients had been treated by vena section in the past which brought little or no benefit. Six of these patients have been followed-up for 12 years. None has developed polycythemia vera, none has developed tumor, and none has developed splenomegaly. Dr. Russell suggested that a definite syndrome is associated with hypertension which is characterized by these patients, who are all tense, stocky, white men, heavy smokers with hypertension, and have a recurring of prior manifestations. Patients with this syndrome have been described earlier by Gaisback. This is one form of polycythemia which is not true polycythemia. There is no proof of increased erythropoietin in their blood, nor is there proof that vena section prevents further arterial disease.

Dr. Charache discussed the problem of blood viscosity and vascular complications in patients with polycythemia vera. When the hematocrit is high, viscosity rises. With the increase in the fluid viscosity, the heart's action to pump, in theory, must be greater. In actual fact, patients with polycythemia vera have no heart trouble; rather they have small hearts but they do suffer from intravascular thrombosis. Dr. Charache described the properties of fluids in terms of viscosity and shear and the theoretical relationship between these two. When shear decreases vis-



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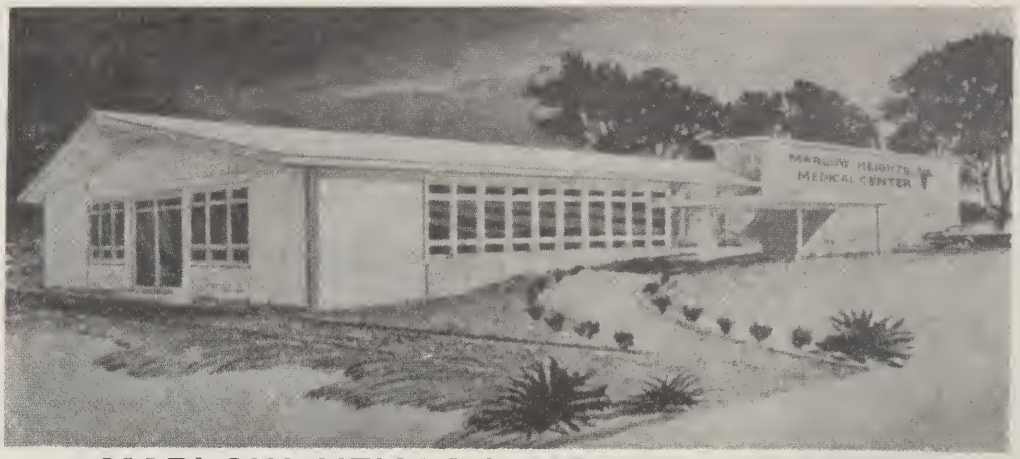


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cosity increases and an increased hematocrit exaggerates the viscosity. Blood volume is increased, vascular distention occurs, flow is slower, viscosity is greater, and the hazard of thrombosis is greater. Dr. Charache showed the effect of a reduction of hematocrit upon shear and viscosity and gave a satisfactory explanation for the treatment of these patients by repeated phlebotomization.

After the scientific session the business session was held. The following new members were elected to active membership: **Maxwell D. Lai, MD, Samuel M. M. Lumpkin, MD, Edward E. Morse, MD, Carl J. Pauerstein, MD, Kirby L. C. Von Kessler, MD,** and **Kerr L. White, MD.**

The following members were elected to active membership by transfer from associate status: **Arthur E. Cocco, MD, Paul D. Meyer, MD, Emile R. Mohler, Jr., MD, Morton M. Mower, MD,** and **Mary Betty Stevens, MD.**

The following associate members were elected: **Leslie A. Bard, MD, William M. Coburn, Jr., MD;** and by transfer from active status: **John M. Atwood, MD,** and **Nathaniel M. Beck, MD.**

A motion made at the last meeting by **Samuel Morrison, MD,** that "if the membership of the Baltimore City Medical Society wish to instruct their delegates on an issue they may do so, and the delegates must be held to this instruction," was the subject of a lively and spirited debate. The motion was carried.

Dr. Arthur Siwinski reported, for information of the members of the Society, that **Russell Fisher, MD,** had requested a distribution of a flyer concerning information regarding criminal abortions and the legal implications thereof. This had been done in the preceding mailing, and Dr. Siwinski explained the flyer.

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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BALTIMORE COUNTY

The February meeting of the Baltimore County Medical Association was held at the Western Electric Company, Cockeysville, at the invitation of the medical director, **Samuel Bacon, MD,** and the executives of the Company.

After a delicious buffet luncheon, Dr. Bacon welcomed our members and introduced two executives, who explained the work of the company at this new plant. A tour was conducted for our members.

The following physicians were elected to active membership: **Leonard Berger, MD, Barbara A. Solomon, MD, John M. Krager, MD,**



Samuel Bacon, MD, medical director, Western Electrical Company, addressed the Baltimore County Medical Association at its February meeting.



A tour of the Western Electric Company's new plant in Cockeysville was part of the program. Left to right, Kevin Quinn, MD, William Pillsbury, MD, Theodore Patterson, MD, President Edward Krieg, MD, Vice President Gordon Grau, MD, and guide.



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; danger of cardiac decompensation; or symptoms of peptic ulcer; renal, ; or cardiac damage; history of drug ; history of blood dyscrasia. Because ncreased possibility of toxic reac- he drug should not be given when the is senile or when other potent therapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage in Rheumatoid Arthritis
Initial: 3 to 6 capsules daily in divided doses It is usually unnecessary to exceed 4 capsules daily. A trial period of 1 week is adequate to determine response; in the absence of favorable response, discontinue.

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Edward Warren Hopf, MD, Henrietta Moritz, MD, Abdul A. Rahman, MD. Irving Freeman, MD, and Sigmund Amitin, MD, were elected associate members, and Anatol Oleynick, MD, was elected affiliate member.

Mrs. Dorothy E. Holman

MONTGOMERY COUNTY

Seruch T. Kimble, MD, the 1966 president of the Montgomery County Medical Society, like quite a few doctors, has been able to manipulate time so as to get considerably more than 24 hours in each day. He seems to have the genius of doing a great many things well without slighting any of them.

Dr. Kimble was born in Washington, DC, on February 21, 1921. He attended George Washington University, receiving his AB in 1941 and his MD in 1945. He interned at Presbyterian Hospital in Chicago.

While a student at G.W., Dr. Kimble met Miss Helen Matchett, whom he subsequently married. Mrs. Kimble's father is General Henry J. Matchett, who helped plan the D-Day invasion of Normandy. The Kimbles with their two girls and five boys live in their roomy and delightful new home off Georgia Avenue, south of Olney.

Dr. Kimble is a member of the Association of American Physicians and Surgeons, the International Society of Internal Medicine, National Academy of Arts and Science, the American Geriatrics Society, Pan-American Medical Association, the New York Academy of Sciences, and the Eastern Psycho Analytical Association. He is a diplomate of the American Board of Internal Medicine. Locally he is affiliated with the Medical Arts Society of the District of Columbia, the Montgomery County Mental Health Association, treasurer of the Montgomery County Foundation for Community Health, a past member of the Board of the Montgomery County TB and Heart Association, and past president of the Civitan Club.

Dr. Kimble is on the staff at Suburban Hospital, Washington Sanitarium, and Holy Cross Hospital.

* * * * *

William C. Swatek, MD, has been elected pre-



The Montgomery County Gynecological Society, newly formed specialty group, had its founding banquet at the Linden Hill Hotel, Bethesda, on February 22. John B. Brady, MD, is president of the group; George A. Maxwell, MD, is vice president, and George J. Ellis, Jr., MD, is secretary-treasurer.

sident of the staff of the Washington Sanitarium and Hospital for 1966. He also heads the Pathology Department.

Other physicians elected to head departments for 1966 are: **Abraham Danish,** medicine; **Lysle Williams,** surgery; **Charles Hughes,** obstetrics; **Eino Magi,** general practice; **Herbert Diamond,** pediatrics; **George Innocent,** radiology; **Cyril Hardy,** psychiatry; **Ervin Chapman,** anesthesia, and **Torsten Lundstrom,** physical medicine.

* * * * *

Clifton R. Brooks, MD, has been accepted in the South Eastern Allergy Association.

* * * * *

The American Medical Association, at its Public Relations Institute, at the Drake Hotel in Chicago in 1965, displayed the Physicians Directory, "Choosing Your Physician," and the "Welcome Doctor" booklet from the Montgomery County Medical Society.

* * * * *

The Montgomery County Medical Society recently sponsored a one-day symposium on Medicare.

Invited to the symposium were hospital administrators, chiefs of the hospitals' medical staffs, nursing home administrators, county health personnel, and representatives from welfare agencies.

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References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

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The symposium was arranged by the society's Committee on Medicare, which was appointed shortly after the passage of PL 89-97 last year.

Seruch T. Kimble, MD, the society's president, pointed out that the society recognizes that Medicare "will affect every physician, hospital, nursing home, and other health facilities as well as the majority of families in Montgomery County.

"The reality of the problems that will arise in our community has little to do with approval or disapproval of the law," he continued. "We hope that the fund of information and statistics that came out of the symposium will benefit all."

WASHINGTON COUNTY

A discussion of "Life Threatening Microbial Diseases and Their Treatment," a brief interesting trip through Pakistan, an upcoming sports injuries seminar, and a new executive secretary were reported at the March meeting of the Washington County Medical Society.

Theodore E. Woodward, MD, professor of medicine at the University of Maryland, reviewed some of the more occult causes of bacterial problems in an interesting discussion of "Life Threatening Microbial Diseases and Their Treatment." Dr. Woodward's presentation included colored slides and a review of his experiences while on sabbatical leave in Pakistan.

James W. Banks, MD, reported on the progress of a sports injury seminar, of which he is chairman, to be held April 2. Coaches and trainers from secondary schools and colleges within a 50-mile radius of Hagerstown have been invited. Attendance is anticipated at 150-200 people.

The resignation of **Mrs. Joyce Harlacher** as executive secretary was accepted with regret. **Mrs. Jacob G. Warden,** whose physician husband was greatly respected and admired, has been appointed as the new executive secretary of the Washington County Medical Society.

Robert vL. Campbell, MD, discussed medicine's viewpoint on Medicare with the Hagerstown Kiwanis Club. He explained that the decision

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for compliance or noncompliance is made by the physician himself.

Richard A. Young, MD, society president, was re-elected to the executive board of the Mason-Dixon Council of the Boy Scouts of America. Re-elected as members at large were: **J. Walter Layman, MD**, and **Stanley Macht, MD.**

The records made by athlete **John Stouffer, MD,** during the 1965-66 winter season of the YMCA placed his name at the top of the "over age 30" category. He was timed for three miles in 17"30.0 and for the 880 in 2:22.2.

New members of the Washington County Medical Society are: **George W. Comstock, MD, T. W. Cooper, MD, John J. Donoghue, MD, J. E. Harrell, MD, R. E. Keyser, MD, A. Lazo, MD, J. P. Norris, MD, C. M. Snyder, MD, D. W. Whitcomb, MD,** and **C. R. Wierer, MD. John Turco** has returned from residency in Ob-Gyn. The society also welcomed the new county health officer, **Neil Gordon, MD.**

John W. Clark, MD, DDS

WICOMICO COUNTY

Mr. James Woodson, director of the Salisbury Social Security office, and **Mr. Richard Morris,** of the Charlottesville (Va) regional office of Social Security, were guests of the Wicomico County Medical Society at its March meeting. They discussed the mechanisms by which the Medicare program will be implemented and the coverage which will actually be provided.

At the same meeting, the society expressed opposition to HR 9256, a bill to provide mortgage insurance and loans for group practice facilities. The bill was at that time under consideration by the Subcommittee on Housing of the House Banking and Currency Committee.

Other business included approval of the application of **George H. Henning, MD,** for active membership in the society.

Mrs. Kit Hargreaves

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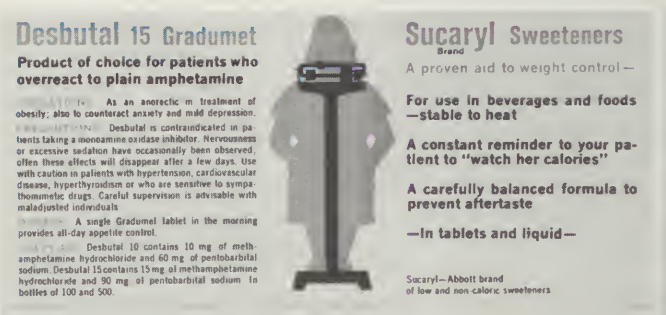
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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Curriculum Needed in Medical Technology

John E. Adams, MD

It can only be hoped that the recent series of three articles in *The Evening Sun,* under the title of "Test Tube Crisis," which described the origins and effects of the critical shortage of medical technologists, will arouse sufficient public interest to stimulate appropriate remedial action. There is no doubt that diagnostic laboratory work suffers in accuracy and promptness of service because of this shortage, which is becoming more acute almost daily and which, to some extent, forces pathologists to settle for less qualified and less highly motivated personnel. Night laboratory coverage, for example, is frequently provided by personnel with variable laboratory backgrounds, and the quality of night laboratory work may suffer. The demand for technologists far outstrips the supply, and there are not enough technologists to staff the existing laboratories during the day, much less at night.

Most hospitals in Baltimore would be delighted to offer technologist training programs, given the required college or university affiliation and a reasonable flow of students. Such programs are not maintained because there are no students to place in them. The lack of students is largely the fault of the undergraduate schools because of their failure to recognize and accept their responsibility to offer curricula for medical technology students. Pathologists have repeatedly and unsuccessfully solicited for affiliation with any of the many good undergraduate schools in this area. Educators here, unlike those in many other parts of the country, regard medical technology training as vocational training which should not be provided on an undergraduate level. They remain unconvinced that a career in medical technology is a professional career equal in potential for advancement, salary, and responsibility to that found in many other acknowledged professional careers such as nursing and teaching.

It seems unlikely that either University Hospital or The Johns Hopkins Hospital, will, within the foreseeable future, formulate medical technology training programs. These laboratories are completely decentralized and compartmentalized under multiple directors so that no one person or group is interested in championing the interests of medical technology for technologists. Indeed, there is no demand for doing so, since these laboratories remain well staffed with technologists trained by other hospitals who are drawn by the glamor of research activity or by a high salary scale with which other hospitals cannot compete. It would be difficult for a student in general medical technology to receive a comprehensive, well balanced training experience in these laboratories with a continuing lack of central direction of the laboratory as well as of a director of student education. For this reason, technologist training may often be better provided in the average-sized general hospital laboratory where direction is centralized and the opportunity for proper supervision and broad exposure to laboratory science is more accessible.

Even if the university hospitals are unsuited or unwilling to participate in medical technology training to bolster the manpower market they readily utilize, there would seem to be no sound reason for the undergraduate schools of the parent universities not to contribute by providing the curriculum and the appropriate degree in medical technology. Indeed, it would seem to be their obligation to do so.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

VOCATIONAL EVALUATION OF THE HANDICAPPED

L. MYRTON GAINES, JR.
DANIEL MAUCHLINE
JULIAN NADOLSKY
ANNA MILLER
GORDON GEORGE

In 1964 the Baltimore League for Crippled Children and Adults instituted a program for vocational evaluation of handicapped individuals. This report summarizes the results in the first 47 clients and includes data from six months of follow-up.

To be eligible for this program a person must have a medical impairment—physical, mental, or emotional—and must be unemployed because of this impairment. An applicant has to supply his own transportation. He must also be able to take care of his personal needs and have the stamina to put in a six to seven-hour day. With these exceptions, the service has been available to any handicapped person age 16 or older and to any agency working with the handicapped.

The vocational evaluation entailed a comprehensive survey of the client's disability. His overall progress through the program was supervised by a psychologist. In turn, the client was seen and examined by a social worker, physician, and physical therapist; current cases are also being seen by an occupational therapist. Detailed reports of past treatment and evaluation were obtained. The client was then studied by the vocational evaluator. This study began with a battery of standardized psychological tests. Based on the strengths and weaknesses and personal preferences which came to light, the client was then given various work samples and situational tasks which included the use of office equipment, hand tools, and machinery. The emphasis was on the client's ability to perform the task, but an important byproduct was the general observations on work tolerance. The average person required two weeks to complete the evaluation. At the end of this period a staff conference was held to summarize each case. The emphasis then was placed not on the medical handicap but on the residual, functional ability and how this related to the world of work. The results of testing were compared with a pre-established occupational frame of reference.[1,2] This enabled a realistic vocational appraisal to be made on any or all existing occupations rather than a few selected training areas.

Results

By March, 1965, 53 clients had been referred for evaluation, mostly from the Division of Vocational Rehabilitation of the State of Maryland. After preliminary screening, five clients were rejected because their medical impairments were considered too severe. A sixth client was withdrawn by the referring agency because a trial of work tolerance was their aim and not vocational evaluation. The remaining 47 clients completed the evaluation. In all but two there has been a follow-up, at least six months after study at the League.

Age, Education, and IQ

The clients had an age range of 17 to 56 years with a median age of 28 years. There were seven female and 40 male clients. Thirteen were Negro and 34 were white. Fifteen were married, five

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had been divorced, and 27 were single. Their formal education ranged from 0 to 16 years with a median of 10 years. The most valid measure of IQ showed a range from 51 to 126 with a median IQ at 90.

Types of Recommendations

Table 1 lists the individuals according to their major medical impairment. The final vocational recommendation for each category is shown. The vocational recommendations were often specific in individual cases and were extremely diverse for the entire group. For purposes of analysis, however, the vocational recommendations can be grouped into five general categories. Direct job placement and vocational training are the highest recommendations. These two categories imply definite industrial potential.

Personal adjustment training would be the next best recommendation. An individual in this category would be considered to have possible industrial potential, but a period of sheltered work with personal and vocational counseling was considered to be necessary prior to entering the labor

TABLE 1
RECOMMENDATION BY IMPAIRMENT

MEDICAL IMPAIRMENT	VOCATIONAL RECOMMENDATION					
	Number of Clients	Job Placement	Vocational Training	Personal Adjustment Training	Sheltered Workshop	Recreation
Neurologic						
Cerebral palsy	8	1	2	3		2
Cerebrovascular accident	5	2			2	1
Cerebral disease, idiopathic	5	3				2
Paraplegia	5		2	1	1	1
Poliomyelitis	2	1				1
Other	4	2			1	1
Subtotal	29	9	4	4	4	8
Musculoskeletal						
Rheumatoid arthritis	3	3				
Other	5	3	2			
Subtotal	8	6	2			
Psychiatric						
Schizophrenia	5	2	1	2		
Psychoneurosis	1		1			
Subtotal	6	2	2	2		
Cardiac						
Subtotal	2	2				
Miscellaneous						
Subtotal	2	2				
Totals	47 (100%)	21 (45%)	8 (17%)	6 (13%)	4 (8%)	8 (17%)

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market. Personal adjustment training is not designed to impart a specific, salable skill to an individual but to equip him with good work habits which employers expect in all employees. These include such basic things as promptness, regularity of attendance, proper dress and grooming, ability to establish and maintain satisfactory interpersonal relationships, etc. No matter how talented or skillful a person may be, regardless of his intelligence or artfulness, these attributes are essential to maintaining employment.

A recommendation of sheltered workshop meant that the staff believed that such employment was the highest possible goal and industrial placement was unrealistic.

A final recommendation was that a client was suitable only for recreational activities.

Medical Impairments

There were 29 clients with neurologic impairments; eight, musculoskeletal; six, psychiatric; two, cardiac; and two, miscellaneous diseases. The medical impairments have been arranged in groups in the table for emphasis. Cerebral disease, idiopathic, probably represents an admixture of pathologic states. Encephalitis was suspected in three and a brain tumor in a fourth, whereas there was no clue to etiology in the fifth case. "Other" neurologic includes one case each of subdural hematoma, cerebellar ataxia, myasthenia gravis, and muscular dystrophy. "Other" musculoskeletal includes one instance each of osteogenesis imperfecta, scoliosis, herniated lumbar disc, amputation of leg, and multiple congenital deformities. The five clients with schizophrenia were all in partial remission after treatment. Both of the clients with cardiac impairments had coronary heart disease with a past history of myocardial infarction. The miscellaneous category comprises one person with cirrhosis of the liver and one who is deaf.

Impairments and Recommendations

As shown in the subtotals in Table 1, eight clients with neurologic impairments were considered capable of recreation only. No individuals with other medical impairments were considered to be so severely handicapped. Four clients, all with neurologic diseases, were deemed suitable only for a sheltered workshop. Four of the six clients for whom personal adjustment training was advised had neurologic diseases. With the exception of two individuals with schizophrenia, for whom personal adjustment training was suggested, all clients with non-neurologic impairments were considered to be proper candidates for vocational training or direct job placement in competitive employment. There is, thus, a distinct pattern of recommendations according to medical impairment with neurologic disease affording the most severe vocational handicap.

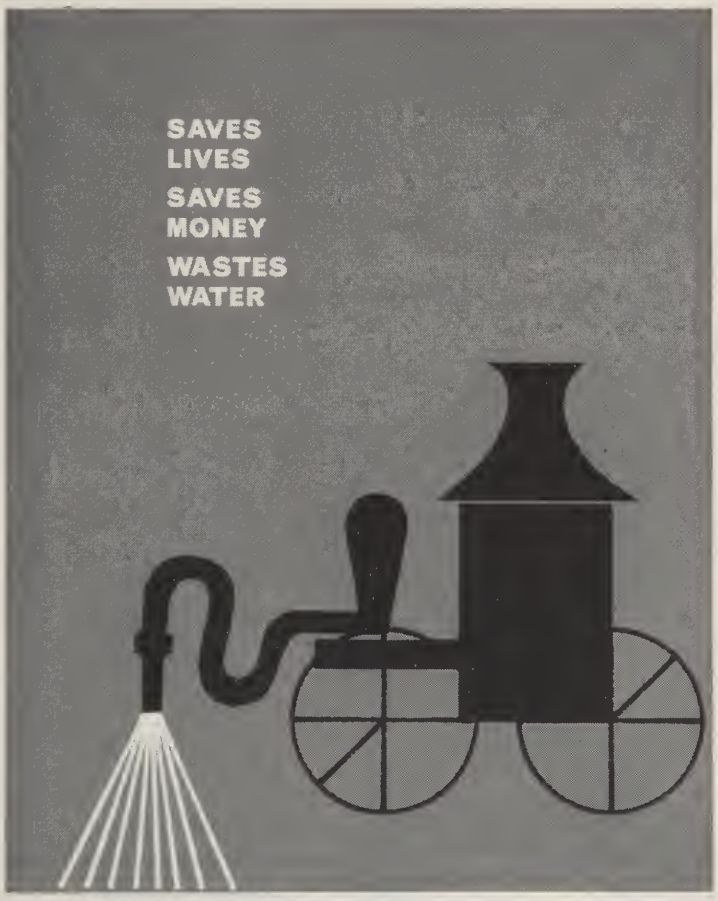
Not apparent from the table, but brought out clearly by individual case review, is the fact that the loss of higher functions of the cerebral cortex is most disabling. The basic intelligence, the ability to reason and make judgments, and the skills of communication were the most important requirements for vocational rehabilitation. Many of the clients with neurologic impairments had low intelligence quotients, exhibited an organic brain syndrome, or were aphasic.

With the exception of a few with borderline intelligence quotients none of the clients with non-neurologic diseases had such deficits in cerebral function. For example, of the eight clients for whom recreation was considered the highest goal, six had measured IQ's below 80 and the other two had organic brain syndromes. Four of the 8 had severe aphasia. There were only two (one poliomyelitis and one muscular dystrophy) in whom severe paralysis of extremities rather than cerebral deficiency was the major bar to employment. Even these two clients had dull normal intelligence, which prevented them from adapting to very sedentary work.

A sheltered workshop recommendation for four paralytic clients was related to severe aphasia in three and mental retardation in one. The clients recommended for personal adjustment training tended to have mild to moderate impairments. Only two of these six clients had low intelligence or communication problems. Vocational training was suggested for eight clients. One had an IQ of 78 and another had minimal aphasia and borderline intelligence. Neither of these two have succeeded in training programs. The remaining six individuals had no cerebral deficit and are achieving their goals in training.

Direct job placement was recommended for 21 clients. Only four of this group had an IQ below 80. Four of these clients had mild aphasia and one had organic brain syndrome.

Personal adjustment training was generally



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TABLE 2
STATUS AT FOLLOW-UP

	Number of Clients	Job	Training	Sheltered Workshop	Unemployed	Unknown
Vocational Recommendation						
Job placement	21	9 (43%)	1	2	7	2
Vocational training	8		5 (63%)	1	2	
Personal adjustment training	6		1	1	4	
Sheltered workshop	4			3 (75%)	1	
Recreation	8				8 (100%)	
Medical Impairment						
Neurologic	29	4	3	5	16	1
Musculoskeletal	8	2	2	2	2	
Psychiatric	6	1	3		2	
Cardiac	2	1				1
Miscellaneous	2				2	
Totals	47 (100%)	8 (17%)	8 (17%)	7 (15%)	22 (47%)	2 (4%)

found to be suitable for young, single men. There was no other correlation between age, sex, race, or social status and the results of evaluation. There was a trend discernible in the previous work history. Those clients who had been out of work for more than two years before referral tended to receive workshop or recreation designations, whereas those individuals who had been unemployed for less than two years tended to be placed into job or training categories. This trend may be artificial and reflect only the varying severity of the medical impairments. Young clients with no previous work or a poor work history tended to be recommended for vocational training or personal adjustment training.

Follow-up Data

A follow-up has been obtained on all except two clients at least six months after evaluation. The status at follow-up is summarized in Table 2. In this table the status at follow-up is contrasted to the initial recommendations and the major diagnostic headings. Of 21 clients recommended for job placement, nine have actually secured employment. Five of the eight individuals in the training category are receiving their suggested vocational training. Of the six recommended for personal adjustment, one was in training, one was in a sheltered shop, and the remainder were idle. Three of the four clients recommended for a sheltered shop were so employed, and two other clients who had been recommended for industry were in a workshop for the handicapped. None of the clients from the recreation category were found at work. The follow-up results confirmed that neurologic impairments afford a greater vocational handicap than other diseases.

Case Reports

The five clients who were paraplegic were very instructive and illustrate many of the aforementioned points.

S.W. was a 29-year-old, married, Negro man with a past work history of unskilled labor. He had suffered a traumatic spinal cord transection at the level of the twelfth thoracic vertebra two and a half years before. Despite marital and emotional problems he had fair motivation. He had learned to give complete self-care. He had an IQ of 105. Based on the aptitudes revealed in evaluation it was recommended that he be trained as a bookkeeper. This client is now in the Woodrow Wilson Rehabilitation Center receiving vocational training as a bookkeeper.

B.B., a 27-year-old, single, Negro man, had an almost identical severe paraplegia, having also had trauma with severance of the spinal cord at the twelfth thoracic vertebra three years before. In contrast to S.W., however, B.B. was mentally retarded with an IQ of 69. No doubt related to this, he had never learned to control his inconti-

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nence. This client had fair motivation and an unskilled labor background. Evaluation revealed no vocational potential. He was recommended for a sheltered workshop. Plans for this have been delayed because of further surgery to help correct his urinary incontinence.

L.M. and W.B. present contrasts of individuals with much milder paraplegia. Both had neurologic damage at the fourth lumbar level with resultant partial paralysis and anesthesia of their lower legs and urinary incontinence. The cause was an unknown type of bone disease in the case of L.M. and a spina bifida with meningomyelocele in W.B. Both clients could walk with the aid of braces. L.M. was a 53-year-old, single, Negro woman who had been schizophrenic but was in remission while taking a phenothiazine medication. She had an IQ of 51, which was a valid measure of her observed functional status even though it might not have reflected her true intellectual capacity. She could not concentrate, had difficulty with any instructions, and performed all activities slowly. The evaluation discovered no vocational potential, and recreational activities only were recommended. In follow-up she was unemployed and inactive at home. W.B. was a 21-year-old, single, white man. Though immature and anxious, he had an IQ of 100 and seemed well motivated. He had aptitudes for clerical work, and training as a clerk-typist was suggested. In follow-up this client was succeeding in a secretarial course and was engaged in part-time work as a radio dispatcher.

C.G., an 18-year-old, single, Negro male had received a gunshot wound at age 15. This produced a spinal cord transection at the first lumbar level. He could ambulate slowly with bilateral leg braces and crutches but preferred a wheelchair. Antedating his injury he had chronic vesicle neck obstruction and had been partially incontinent of urine all his life. With this as an excuse he had remained at home and had no formal education. Psychologic evaluation revealed an inordinately dependent boy due to maternal overprotection. His IQ was 82. Evaluation revealed no vocational aptitudes at that time but much potential for the future if he could be matured. It was recommended that he receive personal adjustment training while working in our sheltered shop. Unfortunately, he dropped this activity promptly, and follow-up reveals that his status is unchanged.

Discussion

Throughout the vocational evaluation program the Baltimore League for Crippled Children and Adults has tried to emphasize important principles of rehabilitation. First, one must concentrate upon the residual ability of the handicapped and not the disability. This is a reversal of the classical medical interest. Where the physician has primary interest in diagnosis and treatment he must concentrate on the diseased part and not the healthy part. In our evaluation every attempt has been made to uncover and use the residual strengths and attributes of the individual. Second, one must be concerned with the functional status and not the anatomic damage or pathologic diagnosis. The medical handicap must be interpreted in functional terms that will allow the vocational evaluator to assign work that is realistic for the particular individual. The period of observation in a work situation during the evaluation was, in most cases, essential in this regard.

More than half of all the clients referred for vocational evaluation had neurologic impairments. This fact deserves some explanation because neurologic diseases are not the leading medical cause of unemployment. One obvious reason is that the Baltimore League for Crippled Children and Adults has long been interested in cerebral palsy. This old interest has created a public image which may have accounted for some of the influx of clients with neurologic diseases. Further, at the onset of this program the Division of Vocational Rehabilitation may have had a backlog of neurologic cases that were immediately referred. Other agencies, such as the Maryland Heart Association, were performing evaluations of individuals with other handicaps. All of these reasons may explain a portion of our referral bias. However, this high percentage of neurologic referrals continues. We believe that this indicates that neurologic impairments are the most difficult to evaluate vocationally and represent the greatest challenge in vocational rehabilitation.

At the start of the League's vocational evaluation program there were no preconceived ideas as to which types of impairment were compatible with employment, training, sheltered workshop, or recreational activities. Each case was considered upon its own merits; only in retrospect have distinct patterns of recommendation according to medical impairments appeared. As noted, clients with neurologic diseases had the greatest voca-



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tional handicap. Furthermore, although the extent of paralysis is important, the most limiting factor is the amount of damage to the cerebral cortex, and a disturbance in ability to think, reason, and communicate was the greatest bar to vocational rehabilitation. This should not be too surprising, for rehabilitation has much in common with education.[3] Rehabilitation is really a process of retraining or re-education, and the ability to think and to communicate is essential to the success of either.

The vocational recommendation is the summation of opinion of the highest possible goal for that client, while the follow-up reveals the achievement or lack of it and measures something different. Follow-up information indicates the effect of many factors, including such complex psychologic phenomena as the motivation of an individual and needs for emotional dependency. These were not discussed in the results. Their great importance is recognized in the specific case, but there is no adequate, objective way to measure such factors. The results of the follow-up also reflect family pressures, marital status, family structure, family income, source and adequacy of disability pensions, social strata of family, etc. The follow-up data also mirror the needs and vocational opportunities in the community as well as the feelings of employers about particular handicaps.

The number of clients capable of work who remain unemployed is discouraging but not unusual.[4,5] It points up a need for aggressive vocational placement services to become an integrated extension of the evaluation process. The small sample reported here does not permit a meaningful breakdown of the types of jobs for which clients deemed ready for employment were recommended, but most were in unskilled or semiskilled categories. These are the jobs for which the greatest competition exists and which, consequently, require the most persistence and the best job-hunting knowledge to obtain.

It is a rare individual who can objectively separate his rejection as a potential employee from a rejection of himself as a person, who has enough ego strength to stand up to continued refusals. Development of this ability can be expedited through provision of factual labor market information and other information designed to help the individual objectify the process of job hunting and separate refusals of jobs from attacks upon himself as a person. This approach is not aimed at directly strengthening the client's ego but rather at helping him develop practical and non-stultifying defenses.

Concurrent with these psychotherapeutic activities, practical instruction is needed on how to complete applications, how to be interviewed, how to ferret out job openings, etc. In a really effective placement program, this intensive preparation and training of clients to carry on their own job searches is backed up by extensive job development by the agency's staff, for although it is most desirable to have the client find his own job, there will always be clients who need someone else to develop at least the first job for them. It is apparent that this is a complex subject which requires expenditure of considerable time by highly trained staff.

The lack of achievement of those clients recommended for personal adjustment training is particularly evident and indicates a need in the community for an appropriate vocational adjustment center for the immature handicapped. At the present time there is no agency in Baltimore prepared to mobilize the resources required to deal with this problem as it is presented by the population of which the clients in this study are representative. Experience in other large cities[6,7] indicates that such centers, using work as a medium of communication with the vocationally maladjusted, can successfully return significant numbers of such clients to competitive employment. Vocational adjustment centers attempt to deal with those aspects of the individual's personality which impinge most directly on his adequacy as an employee. By using trained counselors as foremen, detrimental behavior is dealt with in a constructive manner as it occurs in the work situation. Having the counselor on the scene when events occur lends an immediacy and an effectiveness to the counseling process which is lost when clients must be referred to a counselor off the work floor, and there is less danger of distortion in communication when third parties are not involved in client-counselor communications.

Finally, by reducing the case material to its bare essentials for analysis, there is a danger of oversimplification. Only the major impairment is listed, whereas in fact most clients had multiple diseases. The psychologic complexities often defy

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any attempt to classify. It is therefore clear that each case represents a unique problem. The above patterns can serve only as general guidelines.

Summary

This report analyzes the results of vocational evaluation in the first 47 clients referred to the Baltimore League for Crippled Children and Adults. Most had neurologic impairments. It was found that in this sample neurologic diseases produced a much greater vocational handicap than did other types of disease. It appeared that this major difference was explained by the loss of cerebral function and not the motor paralysis in the neurologic diseases. If a person loses the ability to think or to communicate, he is left with little vocational potential.

Follow-up has shown the expected amount of human underachievement. It also revealed certain inadequacies of the community in placing individuals who could work or in the training of others with vocational potential.

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The Heart Page

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The Electrocardiogram in Infants and Children

The basic electrophysiologic principles of electrocardiography are the same in infants and children as they are in adults, but slight changes in the technique make a more technically perfect record. In infants it is important to use the smaller infant limb electrodes as well as the small suction cup infant chest electrode. At times gentle restraint is necessary in order to maintain a stable base line.

P wave.—The average P-wave duration is 0.06 seconds and the wave is less than 2.5mm in height. It is normally inverted in AVR and usually reaches maximal height in lead II. If the duration is greater than 0.08 seconds or the height is more than 2.5mm, atrial hypertrophy is likely.

P-R interval.—In infants and children not only the rate but also the age must be taken into consideration. As a general statement, the P-R interval increases with age and decreases as the rate increases. Occasionally, the P-R interval may be less than 0.10 seconds in a child less than one year old. Up to five years of age the usual range is 0.12-0.14 with a maximum of 0.16 seconds. From 5-16 years the P-R interval usually is less than 0.18 seconds but may be as long as 0.20 seconds. Even though myocarditis may cause an increased P-R interval, such a finding is certainly not diagnostic. A constantly prolonged P-R interval may be a congenital conduction delay with or without coexisting congenital heart disease.

QRS.—In children the duration is usually 0.08 seconds or less, although occasionally it may be as long as 0.1 seconds. As a general statement, a q-wave usually has no significance in an infant's or young child's electrocardiogram. The R-wave is most prominent in the limb leads, AVF, and leads V_5 and V_6. The S-wave is most prominent in lead I, AVR, and precordial leads V_1 and V_2. A r^1 R^1 configuration may be seen in the right precordial leads, being more common in the younger child.

T-wave.—In lead I, the T-wave should be upright. Within the first 24 hours of life the T-wave may be upright in lead V_1 but should become inverted at least by the fourth or fifth day of life. After that time an upright T-wave in lead V_1 in the electrocardiogram of an infant or young child may be due to right ventricular hypertrophy. In the early hours of life the T-wave in V_6 may be inverted but should become upright after that time.

Axis.—In the early months of life the child has a definite right axis, usually being about +135. Sometime within the period between six months and a year, that degree of axis regresses and is usually replaced by a normal axis of approximately +75. These are average ranges only, and a right axis in a child even as old as 15 or 16 is not necessarily abnormal. It only means that the normal right axis found in the electrocardiogram of an infant usually regresses within the first year or so of life to a normal axis and then very slowly becomes relatively more negative over the next 10-15 years.

The diagnosis of ventricular hypertrophy on the basis of voltage alone, unless very marked, is not overly accurate. Of more help is the R/S ratio in the precordial leads.

Right ventricular hypertrophy should be sus-

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pected if the following ratios of R/S in precordial lead V_1 are present or exceeded at the given age: 6 months, R/S 3.5-4.0; 18 months, 2.5-3.0; 3 years, 1.0-1.5; and 6 years and older, 1.0. Right ventricular hypertrophy should also be suspected when there is a deep S-wave in limb leads I, II, and III; a marked right axis deviation of +125 or more; a tall R-wave in AVR; a qR configuration in the right precordial leads; a deep S-wave in the left precordial leads or an R-wave in V_1 or more than 20mm, in height with an insignificant S-wave.

Left ventricular hypertrophy is usually manifest electrocardiographically by tall R-wave in V_{5-6} and deep S-waves in V_1; a R/S ratio in V_1 of less than 1.0 under 1 year of age and less than 0.2 between the ages of 18 months to 5 years; a left axis deviation of more than a −30 degrees under 16 years of age or T-wave inversion in the left precordial leads or a deep Q-wave over the left precordium. As a general rule, if the sum of the R-wave in V_6 and the S-wave in V_1 is greater than 50mm or if the R-wave in I and the S-wave in III is greater than 40mm, left ventricular hypertrophy is probable.

Combined ventricular hypertrophy is manifest by a combination of the findings of right and left ventricular hypertrophy. The most frequent finding is that of the indications of left ventricular hypertrophy plus a tall R-wave in precordial leads V_1 and V_2 or a deep S-wave in lead I.

An infant or child may have any cardiac arrhythmia. The more common ones are premature atrial, nodal, or ventricular beats, first degree A-V block, and paroxysmal atrial tachycardia (PAT). It is frequently the child of six months of age or less who develops PAT. A sinus arrhythmia is frequently found in children and is normal.

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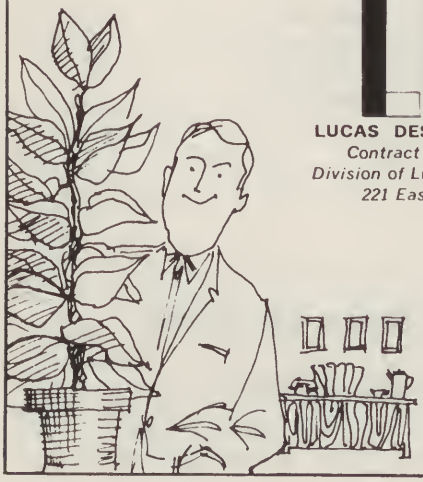
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

GOVERNOR TAWES PROMOTES TREATMENT PROGRAM FOR HABITUAL DRUNKENNESS OFFENDERS

Maryland's Governor J. Millard Tawes has responded to the historic Driver case decision of the U.S. Fourth Circuit Court of Appeals by including in his supplemental budget for the coming fiscal year, planning money for a 200-bed rehabilitation facility for habitual drunkenness offenders.

The decision in the Driver case was that a chronic alcoholic suffers from a sickness and cannot be prosecuted for public drunkenness. The written opinion, by Judge Albert V. Bryan, states:

> The upshot of our decision is that the State cannot stamp an unpretending chronic alcoholic as a criminal if his drunken public display is involuntary as the result of disease. However, nothing we have said precludes appropriate detention of him for treatment and rehabilitation so long as he is not marked a criminal.

The Governor's new program is to be planned and administered by the State Department of Mental Hygiene and has been recommended by the Medical and Chirurgical Faculty of Maryland, the State Board of Health and Mental Hygiene (in its comprehensive mental health plan), Mayor McKeldin's Task Force on Alcoholism Programs for Baltimore, the Baltimore Area Council on Alcoholism, and jurists and legislators across the state. Delegate Harvey Epstein, of Baltimore's Fourth District, was an eloquent spokesman in favor of the appropriation.

A survey conducted by the Department of Mental Hygiene indicates that habitual drunkenness offenders (those individuals convicted of public drunkenness five times in one year) constitute a statewide health problem which traditionally has been the responsibility of correctional agencies. Nearly 300 have been identified in the City of Baltimore.

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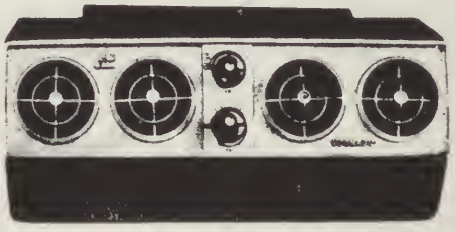
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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 12—Cause Undetermined

This patient was 18 years old, para 1. A previous pregnancy had been terminated by cesarean section because of cephalopelvic disproportion. During the present pregnancy she had received adequate prenatal care and was admitted, at term, in early active labor. Physical examination on admission was not remarkable and revealed no abnormalties of the lungs. Because of the previous cesarean section, a decision was reached to carry out immediate repeat cesarean section.

Under pentothal and cyclopropane anesthesia, a classical cesarean section was carried out uneventfully with the delivery of a 7lb 12oz living boy at 12:30 PM on June 18. Blood loss was not excessive, and the patient was given intravenous methergine after extraction of the placenta. No difficulties were encountered until the anesthetist noted excessive secretions as the abdominal wall was being closed. It became necessary to aspirate the patient's airway frequently.

The patient reacted from her anesthesia to the point where she was beginning to talk, but at this juncture the respiratory secretions became more profuse and râles were noted in both lungs. She was given a digitalis preparation intravenously (preparation and dose not noted). The heart rate rose to 140 per minute and the blood pressure ranged between 120/60 and 90/60. She was also given Solu-Cortef. An endotracheal tube was inserted, but despite suctioning through the tube she failed to respond and was pronounced dead at 3:35 PM.

Postmortem examination revealed early bilateral bronchopneumonia with marked pulmonary edema. The pericardial sac and heart were opened under water, and there was no evidence of air embolism. The pulmonary vessels were not remarkable, there being no evidence of pulmonary embolism. The pathologist lists the cause of death as early diffuse bronchopneumonia with marked pulmonary edema.

Comment

Frequently, as in this case, the committee finds it difficult to be satisfied as to the actual cause of death. In this instance the attending physician did not believe the death was due to bronchopneumonia, since on admission the temperature was normal and the lung fields were clear. He speculated whether this might have been a case of cardiac arrhythmia or some type of anaphylactic reaction.

Members of the committee wondered whether the patient had inadvertently received a pituitary preparation instead of methergine, since the clinical picture was compatible with that of adverse reactions when pituitary extracts are administered with cyclopropane.

The committee voted to classify this as a non-preventable maternal death with the exact terminal cause unclear.

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Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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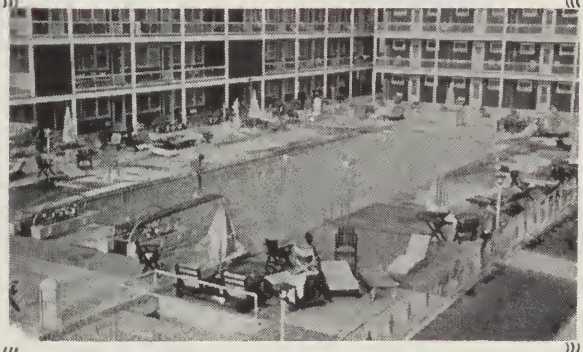
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Syndromes of Minimal Brain Dysfunction in Children

RAYMOND L. CLEMMENS, MD
Associate Professor of Pediatrics and Director of the Central Evaluation Clinic for Children, University Hospital

The term *minimal brain dysfunction* does not refer to a necessarily minor or unimportant impairment but rather to brain involvement which is not readily and grossly demonstrable.[1]

The diagnostic and descriptive categories included in the term refer to children of near average or higher general intelligence with learning or certain behavioral abnormalities, or both, ranging from mild to severe, which are associated with subtle dysfunction of the central nervous system. These may be characterized by combinations of deficits in perception, conceptualization, language, memory, and control of attention, impulse, or motor function.

These aberrations may arise from genetic variation, biochemical irregularities, perinatal brain insults, illnesses or injuries sustained during the years critical for the development of the central nervous system, or from unknown cause. During the school years a variety of special learning disabilities are the most predominant manifestations.[2]

Neurologic disorders in the form of manifest brain damage resulting in mental retardation, cerebral palsy, or seizures can usually be recognized without difficulty. However, the realization that certain behavior, language, and learning problems can be caused by minimal central nervous system disorders has come about only gradually.[3]

Neurologic Factors

Two major categories of neural-anatomic and neuro-physiologic disorders need be considered. First is the group with neurologic damage or cellular destruction as a result of some insult to the brain, called minimal brain damage. Other terms used to designate the same condition are chronic brain syndrome, hyperkinetic impulse disorder, organic brain disorders, and Strauss syndrome. The second group is that with physiologic and maturational deviations which result in marked unevenness of functioning and which many investigators believe represents constitutional idiosyncrasies of genetic origin, called specific language disability.

Children with minimal brain damage present a picture of generalized awkwardness, principally manifest in fine motor incoordination, difficulties in balance, mild chorea-athetosis, and poor handwriting. Hyperactivity, distractability, impulsivity, perseveration, low frustration tolerance, and learning disorders are among the other cardinal manifestations.

Specific Language Disability

Specific language disabilities, the second major category of minimal brain dysfunction, are not the result of neurologic insult but are considered to be the extreme of individual variability (constitutional idiosyncrasy).[4] These conditions occur much more frequently in boys than in girls and are presumed to be of genetic origin. Although overall intelligence is average or higher, there is particular difficulty in learning language

From the Department of Pediatrics, School of Medicine, University of Maryland School of Medicine.

skills, including reading, spelling, and often handwriting. The condition is often associated with delayed speech development, articulation defects, mixed laterality, delayed determination of handedness, fine motor awkwardness, and directionality confusion.

Importance of Diagnosis

The various manifestations of minimal brain dysfunction are such that it is difficult for a child to adjust in an ordinary classroom setting or to achieve at a rate commensurate with his general intellectual abilities. The restlessness, impulsivity, and unpredictable nature of their responses make the usual class setting inappropriate. Teachers become annoyed because the child cannot sit still, conform to usual group instructions, or achieve at expected rates. In many instances secondary emotional disturbances develop which may eventually present as the major problem.

Drug therapy can be of significant value in decreasing the hyperactivity and distractability associated with minimal brain dysfunction.

Once the child's organic difficulties have been recognized, a reasonable understanding of the psychological factors which are commonly present may be achieved. A simple explanation of the clinical diagnosis, the symptoms, and their significance help teachers and parents in their attitude and approaches; this in turn may help these children to cope with environmental stress at home, at play, and in school.

A significant number of seemingly organically impaired children can be managed by a combination of direct parent counseling, structured environment, psychotropic drugs, and special educational planning. Some of these children present a generalized picture of immaturity, to which the mother often responds instinctively with overprotection. Within limits, this may be helpful to the child rather than detrimental, as might be suggested on superficial examination. This point should be considered in our appraisal of overanxious mothers. In more difficult cases and when a weakness in the capacity of the parents to respond to the child's needs are the most important limiting factors, more formal psychotherapeutic intervention may be required.

In the management of children with severe reading disabilities, special educational placement in a small group setting, using multisensory (visual, auditory, kinesthetic, tactile) techniques, will often bring about satisfactory progress in children who have failed to learn by the usual pedagogic methods in a regular classroom setting.



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Dermatoglyphics in Medicine

MIHÁLY BARTALOS, MD
Medical Geneticist
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The use of fingerprints in personal identification is widely appreciated. Less well known is the fact that fingerprint patterns can have characteristic configurations in certain clinical entities and thus be of diagnostic value.

The word "dermatoglyphics" is used in medical literature to describe the skin patternings of fingers, toes, palms, and soles. The dermatoglyphic patterns are composed of epidermal ridges. They are so variable that their characteristics are not duplicated either in another region or in another individual. A person's dermatoglyphic patterns remain unchanged during life. Studies on various biologic aspects of dermatoglyphics by Kristine Bonnevie established the basis for genetic studies on dermal ridge patternings.[2]

The first instance of characteristic dermatoglyphic pattern was discovered in mongolism by Cummins and Workman. In mongolism, palmar abnormalities are not limited to dermal ridge formation but involve the flexion creases as well. The fusion of two palmar creases into the "mongolian" or "four-finger" line (sometimes called simian line) is well known to physicians, as is the absence of one flexion crease on the fifth finger. Flexion creases can readily be analyzed by simple inspection, and they should be distinguished from the dermal ridge patterns, which can be best studied from prints obtained from the subjects. This is especially true for newborns where the ridges are less distinct.

On the fingers and toes one can find the combination of three basic patterns which are referred to as arch, loop, and whorl. The loops open toward the radial or fibular and tibial or fibular sides and are designated accordingly. By studying the dermal ridge patterns, one can notice points where three radiants meet and form three angles of approximately 120 degrees each. Such points are referred to as triradii. The most important landmark on the palm is the axial triradius, which is usually located in a proximal position near the wrist crease. In mongolism this triradius is displaced distally and ulnar loops occur frequently on the fingers. Occurrence of patterns in the third interdigital area of the palm was seen more frequently also in mongoloid patients. It is generally believed that the formation of the dermal ridges are determined by several genes spread over many chromosomes.[4] One would therefore expect that the presence of an extra chromosome, with its large number of genes, might well produce characteristic peculiarities in dermal pattern formation. Since it is well established that in mongolism all or a large portion of one of the smallest chromosomes is present in triple dose,[1] the finding of dermatoglyphic peculiarities in this condition is not surprising.

The practical importance of dermatoglyphic studies in mongoloid patients is in their contribution to diagnosis. The clinical stigmata found in mongolism are numerous, yet they may be inconclusive.[3] At present, chromosome analysis is regarded as producing the most reliable diagnostic criterion. Between the reliability of chromosome studies and the commonly noted clinical features, dermatoglyphic studies occupy an intermediary position. Since the study and evaluation of dermatoglyphics is far more simple than are cytogenetic studies, dermal ridge analysis can be used profitably by the practicing physician.

The author is supported by Special Project Grant Number 414 of the Children's Bureau, Department of Health, Education, and Welfare.



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While mongolism is the best known and most frequently observed condition with characteristic patterns of dermal ridge configuration, it is not the only one. A congenital malformation syndrome, referred to as D_1-trisomy syndrome, or Patau's syndrome, is similarly due to chromosomal aberration. The chromosome involved in D_1-trisomy syndrome, however, is not identical with that in mongolism. Dermatoglyphic studies in this condition showed a displacement of axial triradius, and characteristic configuration was observed also on the soles. No characteristic patterns were observed on the fingers, however.

A third example of congenital defects with characteristic dermatoglyphic patterns is the E_{18}-trisomy syndrome, or Edward's syndrome.[5] This condition, too, is due to the presence of a supernumerary chromosome, distinct of those involved in mongolism and D_1-trisomy syndrome. In these cases, dermatoglyphic studies demonstrated the presence of arches on all or most of the fingers.

The three conditions discussed here illustrate the potential of dermatoglyphic studies in medicine. Medical researchers in several medical centers are looking for new conditions with characteristic dermal ridge configurations as well as for new applications for dermatoglyphic studies. In the coming years, we may witness many new findings along this line of medical research. Physicians must always be ready to incorporate new techniques into their diagnostic and curative procedures, of which the study of dermatoglyphics is a recent example.

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illustration after Boyden



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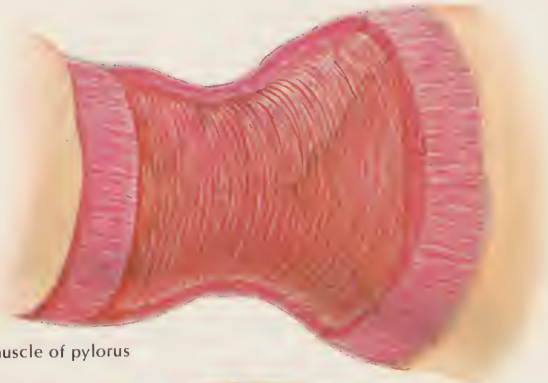
INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

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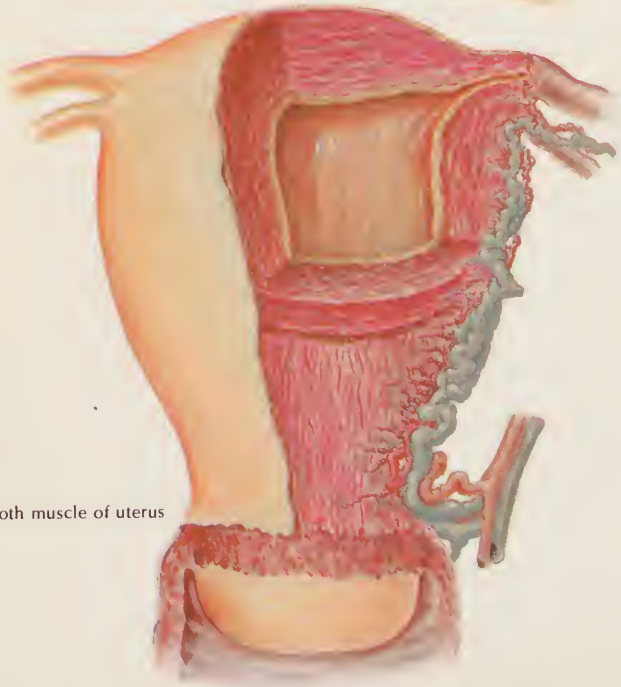
smooth muscle sphincter of Oddi



smooth muscle of pylorus



smooth muscle of colon



smooth muscle of uterus



smooth muscle of urinary bladder

DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

Highlights

RECOMMENDATIONS REGARDING MEDICAL CARE PRESCRIPTIONS

Existing pharmacy regulations permit physicians to write prescriptions for medications which have the normal regulated dosage printed on the manufacturer's label. However, in the case of the "home remedy" type of medications, many patients can take the normal regular dosage and there is no need for the physician to repeat the dosage on the prescription blank. When the physician repeats the dosage on the prescription blank, it costs the State approximately 40 to 50 cents more for the same item. Therefore, the Council on Medical Care has recommended that local health officers ask physicians participating in the County Medical Care Program to refrain from writing directions on "home remedy" type medications when the manufacturer's recommended dosage on the label of the container is the dosage of choice. Although the regulations refer specifically to home remedies, other across-the-counter medications may be prescribed in the same manner.

HOSPITALS SURVEYED ON CIVIL RIGHTS

The Public Health Service is conducting a mail survey of all hospitals in the country to determine their state of compliance with the Civil Rights Act. This will not affect the Department's responsibility in this field, nor will it abrogate the arrangements we have made with the Public Health Service for our joint reviews and investigation of complaints. All private hospitals in the state that participate in the Department's programs and all state-owned hospitals have agreed to comply with the act.

NATIONAL HEALTH BILL SIGNIFICANT

On behalf of the Association of State and Territorial Health Officers, the Commissioner presented a statement to the Senate regarding SB 3008 (Comprehensive Health Planning and Public Health Service Amendments of 1966). From the standpoint of administering health services, this is the most significant federal legislation since 1936, when the first federal grant-in-aid program was initiated.

The proposal is predicated on the fact that health agencies are unique in their potential as centers of excellence for the delivery of health services to the public. It embodies a mechanism for progressively reducing the gap between personal and environmental health services actually available and those which can be provided by practical exploitation of existing scientific knowledge, changes in methods, and future discoveries. The proposal will require us to develop firm and practical health plans by the conjoint efforts of all of the health interests (public, private, professional, and institutional) at the local, metropolitan, regional, state, and federal levels. This planning will be comprehensive. It will include preventive as well as treatment services and environmental health services. It will take the several echelons of health services and key resources—manpower, money, and facilities—into account.

AIR WARNING SYSTEM INVOKED

Some years ago the Public Health Service established a warning system which would forecast weather conditions conducive to intensification of air pollution. These potentials occur a few times a year over a wide area. One such episode took place March 10-13. The area affected was along the Eastern Seaboard and inland, extend-

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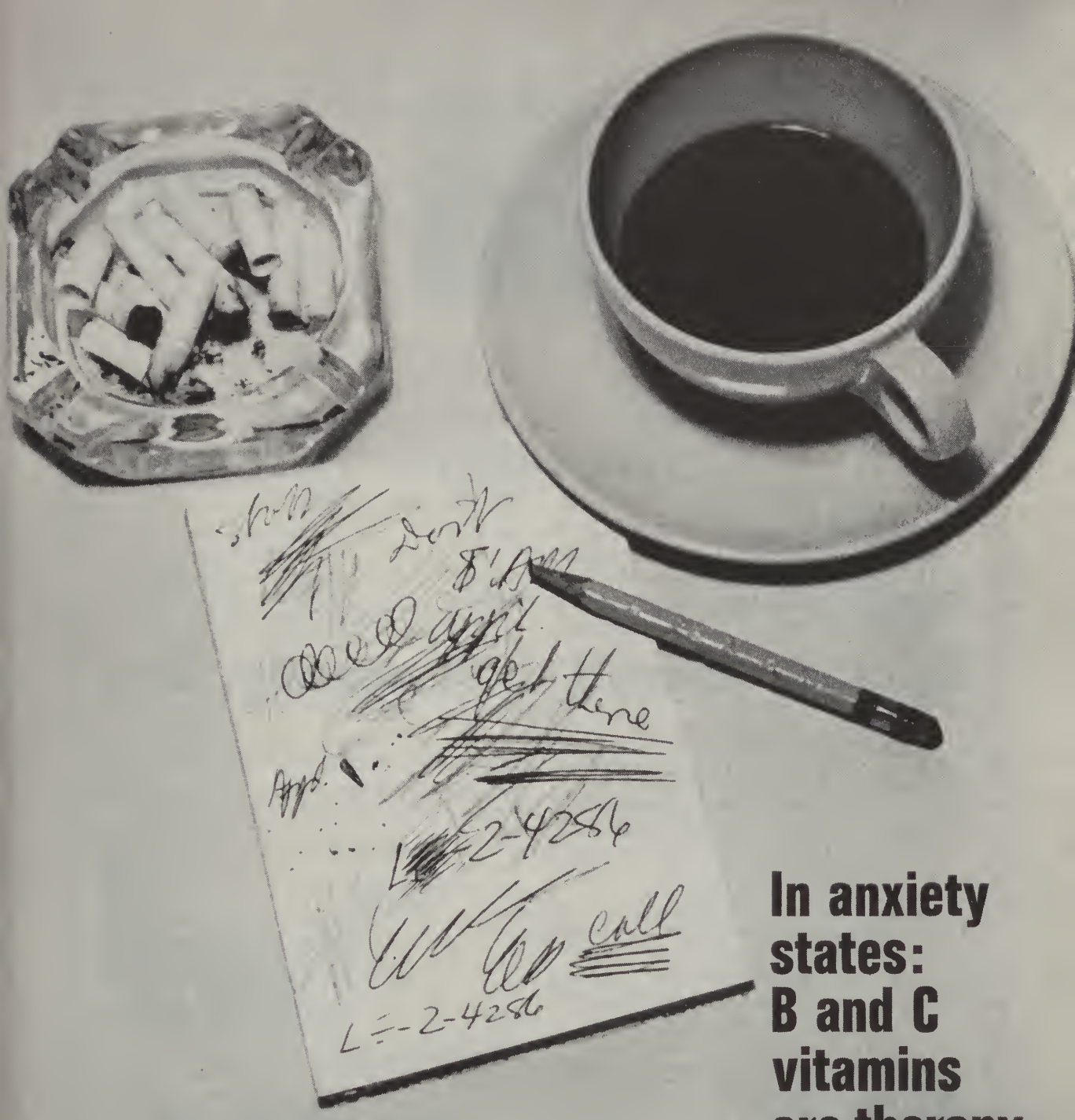
ing from New England and the Great Lakes to include North Carolina. On March 11 the northern limit had moved south to Baltimore, and the condition cleared on the 13th and 14th. During this period, sampling at the several state and metropolitan Baltimore stations was increased. While some elevation in levels of some substances was noted, no significant effect could be determined. All results have not yet been evaluated. There seemed to be no indication for an emergency procedure by the state.

NEW RADIATION PROTECTION RESPONSIBILITY

Occupational Health Division representatives met with a representative of the Atomic Energy Commission to begin negotiations for the state to assume regulatory responsibility over certain radionuclides which have been subject solely to the jurisdiction of the Atomic Energy Commission.

FAMILY PLANNING

The Bureau of Preventive Medicine is cooperating with the Johns Hopkins School of Hygiene and Public Health and the Planned Parenthood Association of Maryland in a series of one-day training sessions, two-day workshops, and two-week seminars on "Family Planning and Public Health." Open to physicians, nurses, nurse midwives, health educators, social workers, public health administrators, and other qualified professionals, the courses are being presented tuition free through the generosity of the Jessie Smith Noyes Foundation.



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Learn To Do Your Part In The Prevention Of Disease

ALCOHOLISM PROGRAM

The City Health Department has issued a new pamphlet describing the procedures and services of its Alcoholism Clinic in the Eastern Health District Building. Prepared for lay distribution, the leaflet is available for physicians' use. The text of the leaflet is as follows:

TRAPPED IN THE BOTTLE? Are you one of the 60,000 people in Baltimore who have a drinking problem? Or perhaps you are a friend or relative of a problem drinker. If so, you should know that no one needs to stay trapped in the bottle because help is available at the Alcoholism Clinic.

WHO CAN APPLY FOR HELP? Baltimore City residents who have a drinking problem can apply directly to the clinic or may be referred by their doctor, clergyman, caseworker or other interested person.

WHAT DOES THE CLINIC DO? At the outset, a complete physical and psychiatric examination of the patient determines whether treatment on an outpatient basis can be started at once or whether a short period of hospitalization would give the patient a better start. After this appraisal of the patient's health, the treatment program is tailored to the individual's needs.

WHY IS HOSPITALIZATION NECESSARY? Sometimes a patient needs specialized care for medical reasons (not just for sobering up) before treatment for an alcoholism problem can begin. Such patients are sent to a hospital for treatment. As soon as his condition permits, both the patient and his spouse are consulted about future treatment on an outpatient basis.

WHAT IS THE CLINIC TREATMENT? Before treatment starts each patient receives a psychiatric and socio-economic evaluation. This enables the doctor to design a treatment program for the individual patient that can be most successful in the light of his present problems and surroundings.

Both the patient and spouse are expected to participate in the treatment program. According to the individual patient's needs, one or several of the following treatment approaches can be used: Individual or group therapy, marriage counseling, medication.

DOES TREATMENT GO BEYOND THE CLINIC? Yes. When indicated, patients may be referred to the Department of Public Welfare, Vocational Rehabilitation, Community Action Program and Alcoholics Anonymous.

WHAT HAPPENS AFTER TREATMENT ENDS? When clinic treatment is terminated both patient and spouse are contacted at regular intervals for follow-up purposes. This can be done either by a scheduled interview at the clinic or by a home visit of a public health nurse or a member of the Instructive Visiting Nurse Association.

WHERE ARE THE SERVICES AVAILABLE? At the Alcoholism Clinic, Eastern Health District Building, 620 N. Caroline Street. You may telephone 732-7110.

Copies of the above leaflet may be obtained from Mr. Harry E. Shelley, coordinator of alcoholism programs, Baltimore City Health Department, American Building, Baltimore and South Streets, Baltimore, Md. 21202; or by telephoning 752-2000, extension 842.

Physicians desiring assistance or consultation may call Abraham M. Schneidmuhl, MD, director, Alcoholism Clinic, Eastern Health District Building, 620 N Caroline Street, Baltimore, Md. 21205; telephone PE 2-7110.

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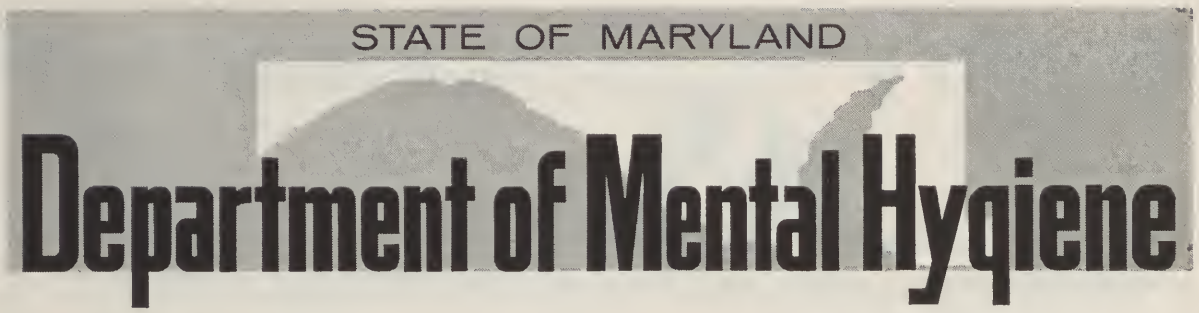
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Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

Fiscal Year	Admissions	Net Releases	Total Expenditures	Expenditures Per Net Release
1955	178,003	126,498	$ 618,087,247	$4,886.14
1957	194,497	150,791	731,875,462	4,853.58
1959	222,791	176,412	849,493,595	4,815.40
1961	253,005	215,600	974,838,616	4,521.51
1963	285,244	247,228	1,084,713,981	4,387.50
1965	314,443	286,989	1,201,979,234	4,188.24

THE NATIONAL SCENE

In 1965, for the fourth consecutive year, reported expenditures in the United States for the maintenance of state and county operated mental hospitals exceeded one billion dollars. This represented an increase of 6.1%, or 69 million dollars, over the previous year's comparable figure. Total maintenance costs have doubled since 1955 and are now almost one-fourth higher than they were four years ago.

Hospital expenditures have continued to go up although the average number of patients in these facilities has decreased steadily. Nationally, a decline in the patient population of 11.9% (from 554,600 to 488,400) occurred between 1955 and 1965. As a result, the average cost of caring for one patient for one day has gone up substantially. In 1955, the national daily per capita was $3.06. By 1965 this had increased 120.3% to $6.74. Despite this improvement, expenditures per patient continue to lag behind comparable figures from federal (VA) psychiatric hospitals.

While these data reflect rising personnel-patient ratios and other improvement in treatment services, they are primarily related to the rapidly increasing patient turnover resulting from shortened periods of hospitalization and the release of many long term patients. As indicated in the table, both admissions and the net number of releases have risen considerably between 1955 and 1965. In fact, this rise has been so large that the average expenditure required to produce one net release is now less than it was 10 years ago.

If present trends continue, the average daily cost per patient must be expected to rise further at the same time that the average total cost of each treatment episode declines. The only alternative to continuing, uninterrupted increases in state psychiatric hospital expenditures is to reduce the number of admissions and to decrease further the average period of hospitalization. This can be accomplished through closely coordinated programs offering a variety of community and hospital services to the mentally disturbed and through the implementation of current and new concepts for the prevention of mental illnesses.

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WHAT YOU SHOULD KNOW ABOUT ENTERTAINING COLLEAGUES

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There are but three valid reasons for making plans to entertain a colleague: 1) introducing yourself, 2) expressing thanks, and, by far the most unusual, 3) common courtesy and friendship.

The method, time, or place chosen to introduce oneself, the spouse, and the family, will not prove to be the end result in itself toward making the proper impression. It will be the means, however, through which you can reveal your genuine desire to be a friend as well as a colleague.

Often the question is asked: As a doctor trying to build a practice, can I entertain colleagues without it appearing that my only purpose is to gain their referrals?

The answer is yes.

Those being entertained are intelligent enough to make referral decisions based on good medicine and certainly not because of good liquor and and hors d'oeuvres. Here are some ground rules to remember:

1. Informal meals at home should be with one couple at a time.
2. Buffet brunches or supper parties are definitely "in."
3. Cocktail parties are "out."

A pleasant meal in the comfort of your home can be one of the greatest ways to get to know someone. Relax and be yourself.

Buffet parties stimulate conversation. People will circulate more freely if the guests are limited to about eight couples. Mixing the guest list with non-physicians is a good idea.

Cocktail parties rarely prove conducive toward sincere, personal exchanges between friends. Who knows when the other fellow will be thinking that "it's just the liquor talking"?

Once you are well established, the rules change drastically. Now the purpose is to show gratitude to those directly or indirectly involved with your success. Larger, more elaborate parties will be acceptable. Having several carefully selected guests for dinner at home or away is permissible.

Caution: Let your normal personality guide your style. No one likes ostentatiousness.

What about afterwards, when you reach the point when big parties and dinners no longer thrill you? Strange as it may seem, you may wish to go back to the beginning principals, small parties and two for dinner, with the emphasis now being on good old fashioned friendship.

Full advantage should be taken of the valid deduction on your income tax returns for professional entertainment. A couple of years ago, the Internal Revenue Service cracked down on such items as entertainment. The IRS will allow deductions where you prove that the atmosphere was complimentary to the occasion. Also, you must, of course, produce an accurate accounting of the expense and a guest list.



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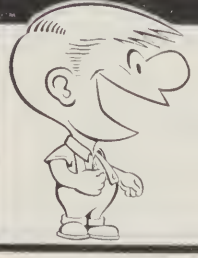
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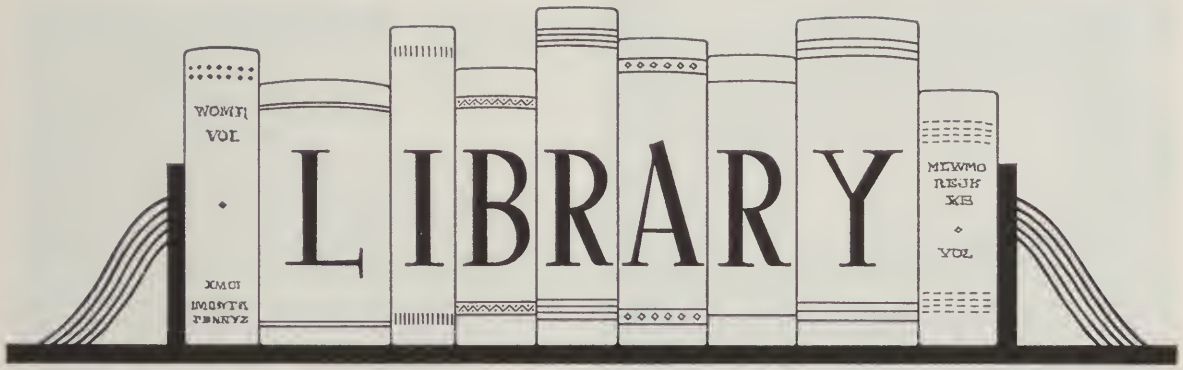
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Louis Krause, MD, Chairman
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Elizabeth Sanford
Librarian

During the past months the library has been newly painted, has increased the capacity of the card catalog with the addition of a 72-drawer case, and is revising the vertical file collection.

Naturally, painting walls, shelves, and ceiling in a library causes more disorganization than in most other facilities, so if service was not as prompt as usual during March, please understand that we probably had to grope around under tarpaulins and ladders in order to find the material you requested. Next time you visit the Faculty building, come into the library and see the improvements.

Since the last Library Page appeared, a collection of new books were shown at the Cecil County meeting in Elkton and the Carroll County Medical Society meeting in Westminster in March. These meetings give the librarians a chance to get acquainted with many of the doctors who do not have an opportunity to visit the library personally, and the doctors a chance to examine new books and request particular subjects or titles which they need. We expect this practice to become more regular as the component societies realize it is an available service. Special requests sent to the library before a meeting will be brought to the meeting whenever possible.

On March 17, representatives of the hospital medical libraries in the state met in the Faculty building. About 40 people attended, predominantly from the Baltimore area. Purpose of the meeting was to discuss the needs of the hospital medical libraries in order to supply their staffs with the most up-to-date information in the most efficient manner, as well as to meet the requirements for accreditation. A number of concrete suggestions as to immediate needs developed; namely, the desire for a good audiovisual center in the state for the use of hospital and other medical libraries; a journal pool on which all the libraries could draw; and, finally, a recommendation that the best solution would be the maintenance of a strong central library to supply the needs of the smaller hospital staff libraries. Since a number of the hospitals outside the Baltimore area were not represented at this meeting, the Library and History Committee of the Faculty would be interested in hearing the reactions of their library committees. Please send any suggestions to Mrs. Sanford.

How Long Since You Visited or Used The Faculty Library?

Recent Accessions

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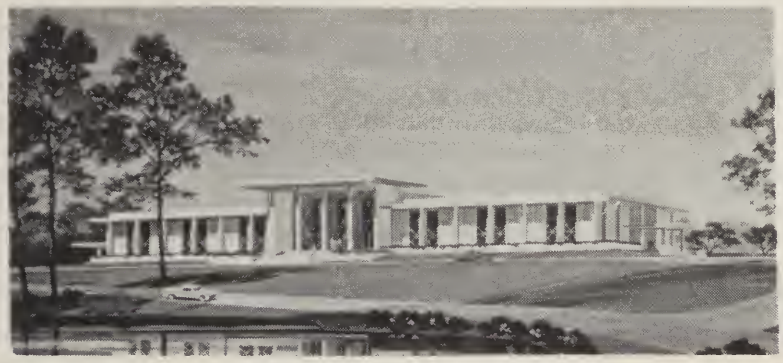
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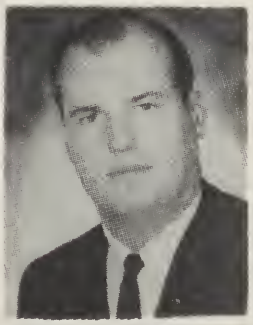
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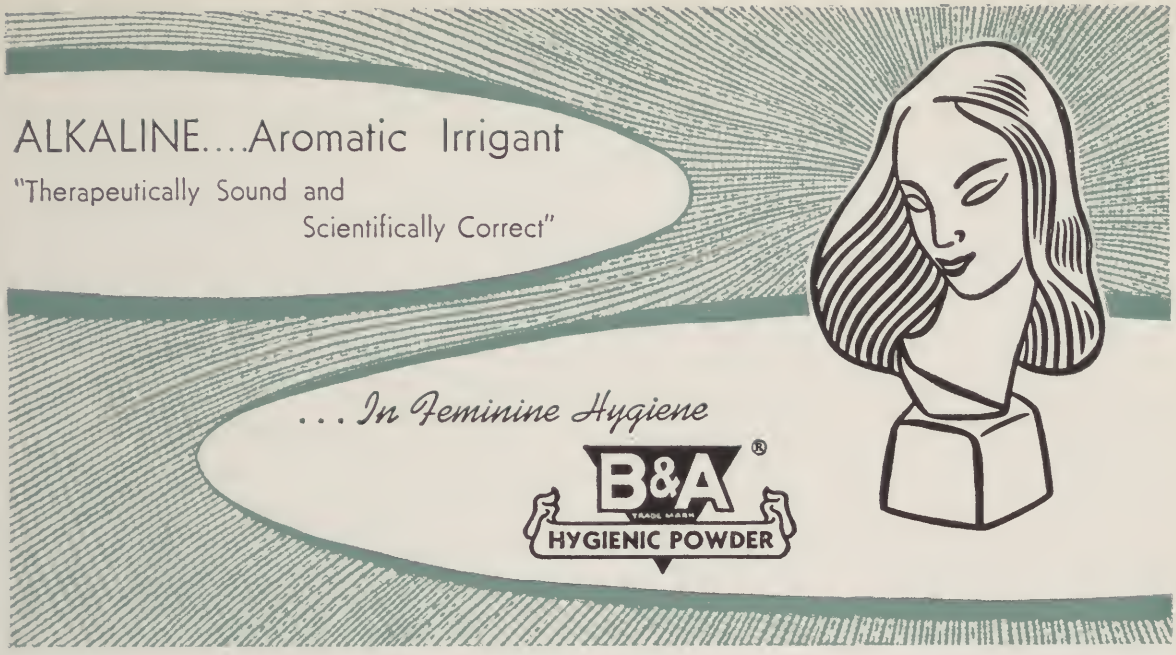
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(Am. J. Obst. & Gynec., 68:559, 1954)

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The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating. mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms. debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11. 1964

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June, 1966

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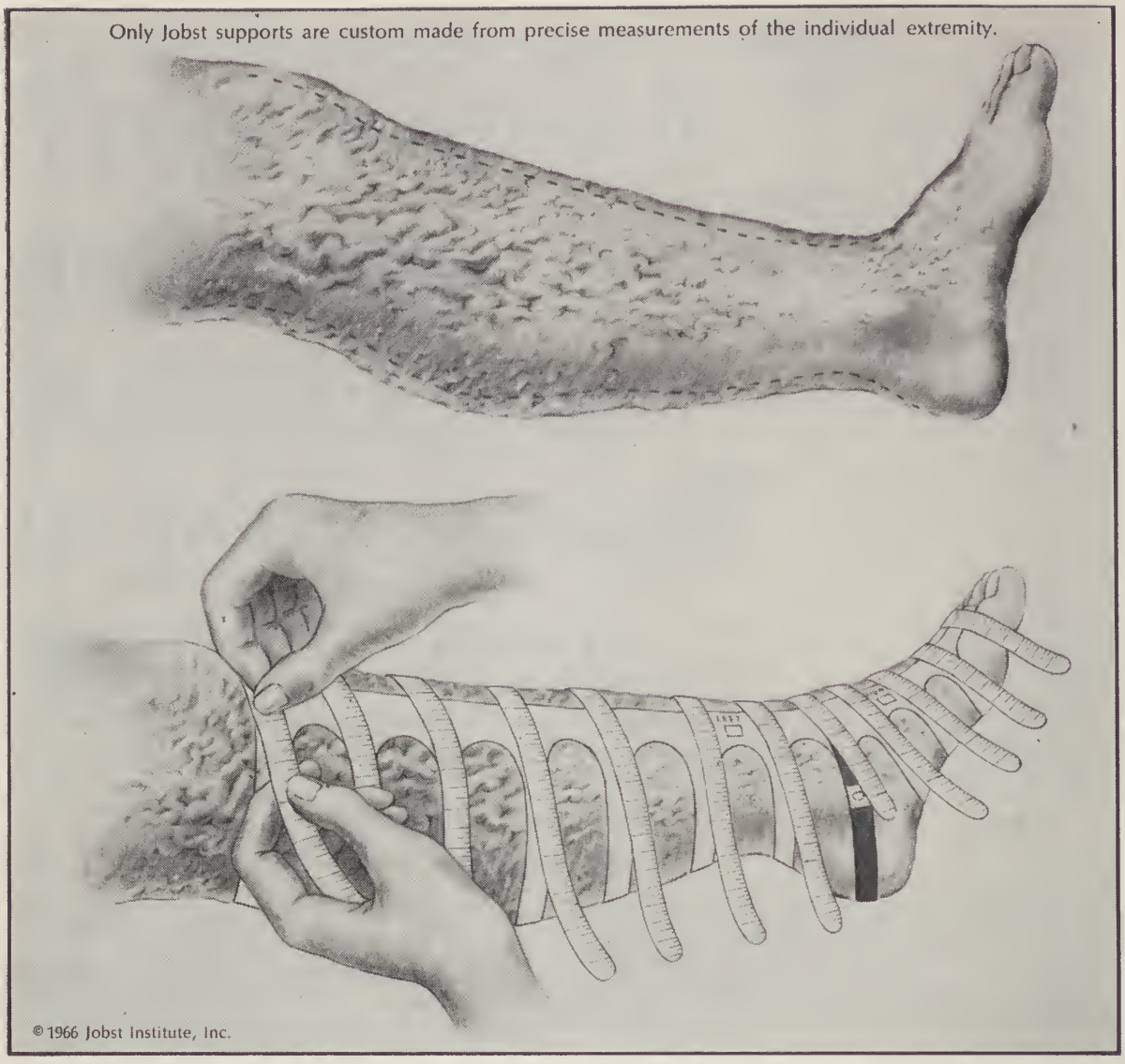
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MEDIC PROGRAM

See Page 160 for list of locations where MEDIC programs may be heard

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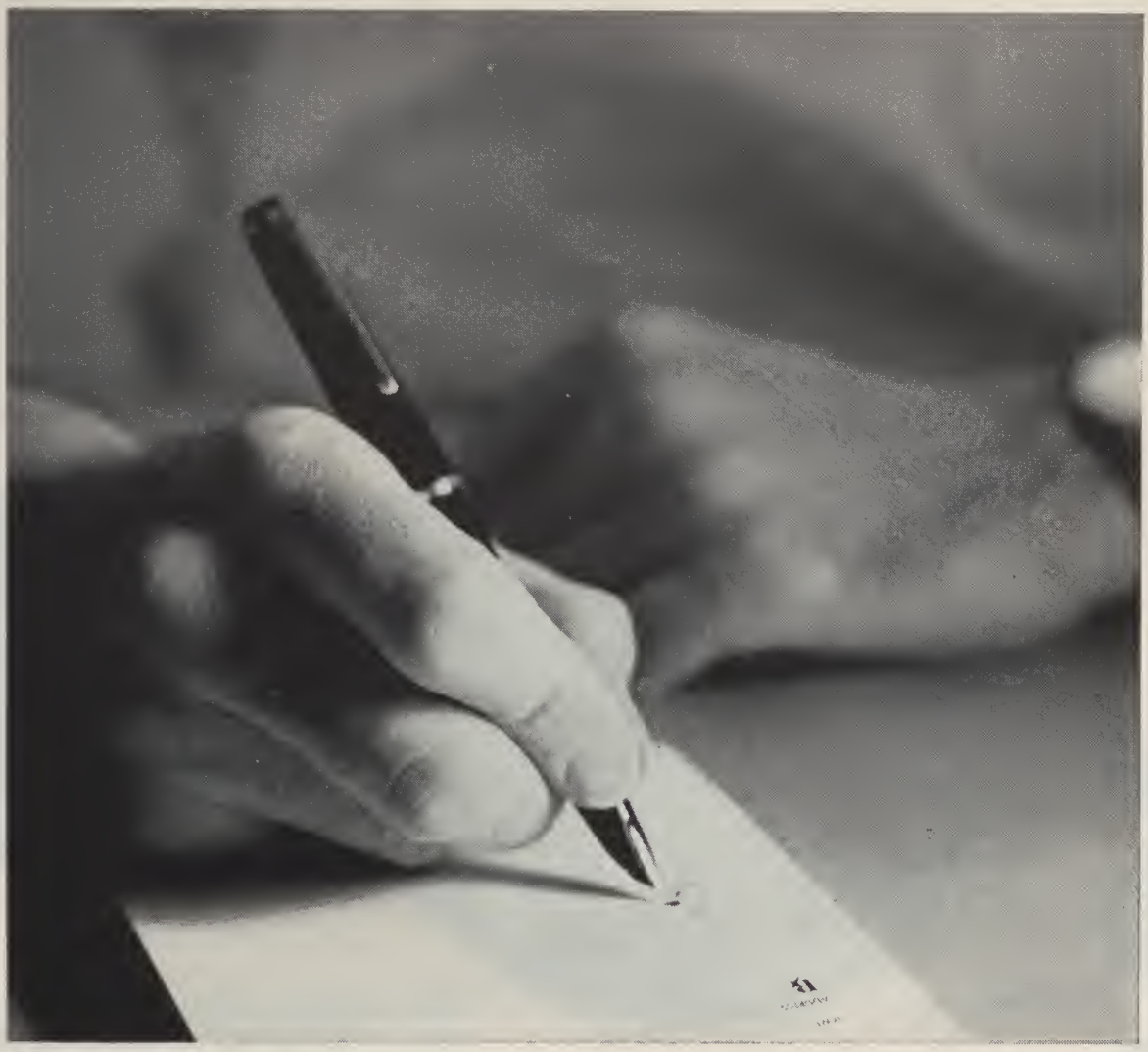
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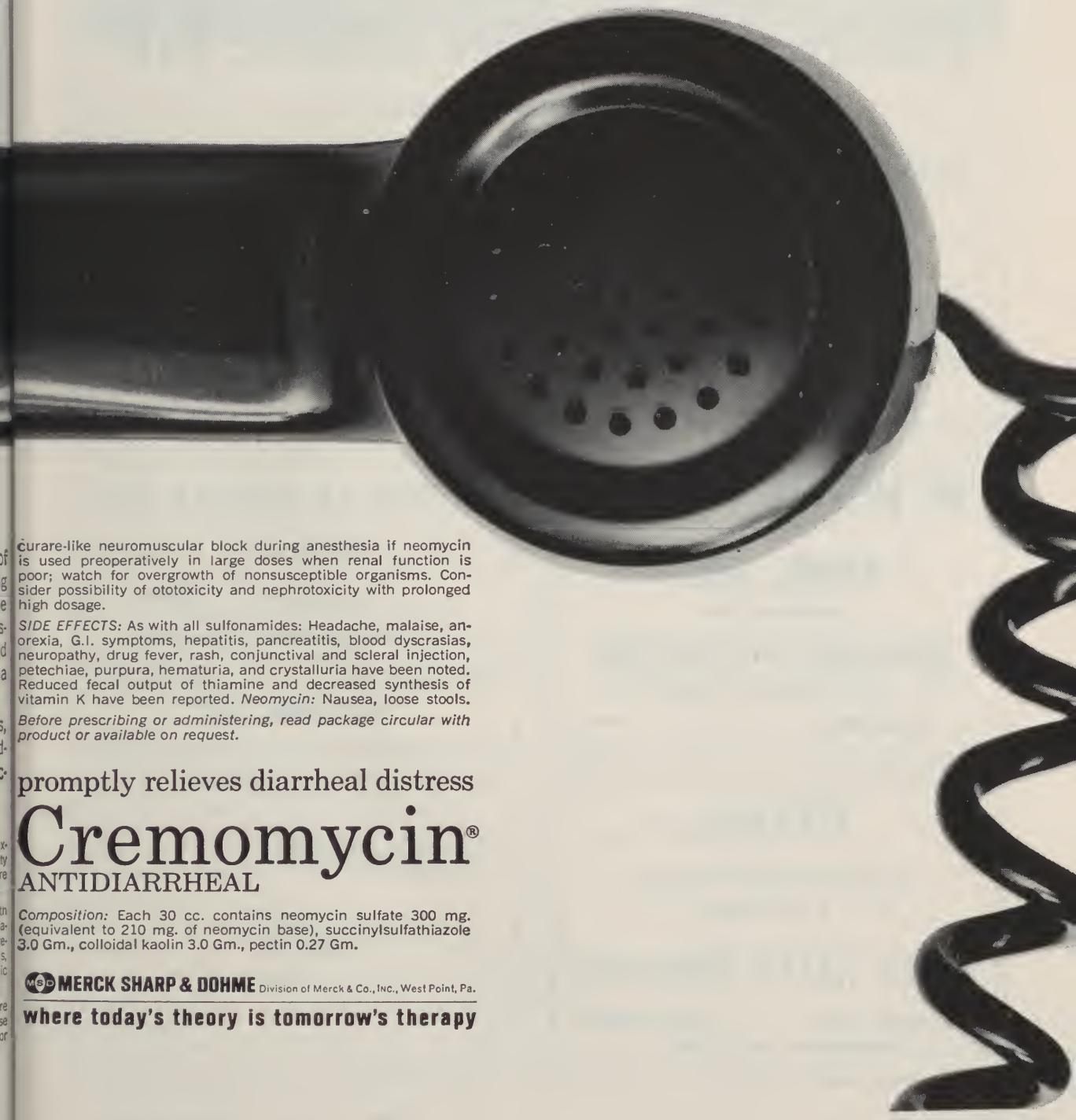
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North Charles General Hospital is doubling its patient care area with the opening of a new 75-bed wing this month. It will contain private and semi-private rooms, as well as a new x-ray unit and equipment.

A new educational suite will also occupy the new quarters. This will consist of a lecture room seating 125 persons, a medical library, and offices for the staff secretary and the Director of Medical Education.

Included in the $750,000 expansion program are alterations to the present hospital building, at Charles and 28th Streets. This includes a new pediatric unit, an intensive care unit, and a new cystoscopic room.

As part of its modernization program, the hospital has reorganized its out-patient department and has expanded its special services.

With several of the downtown hospitals having moved to the suburbs, North Charles General Hospital has had a larger patient load. Because many of its patients are of the working class, the hospital has tried to combine high-level care with low cost.

Buchart Associates, architects and engineers, designed the new addition. Frank F. Favazza & Son, Inc., general contractors, did the building. Other products and services were provided by the firms shown on this and the facing page.

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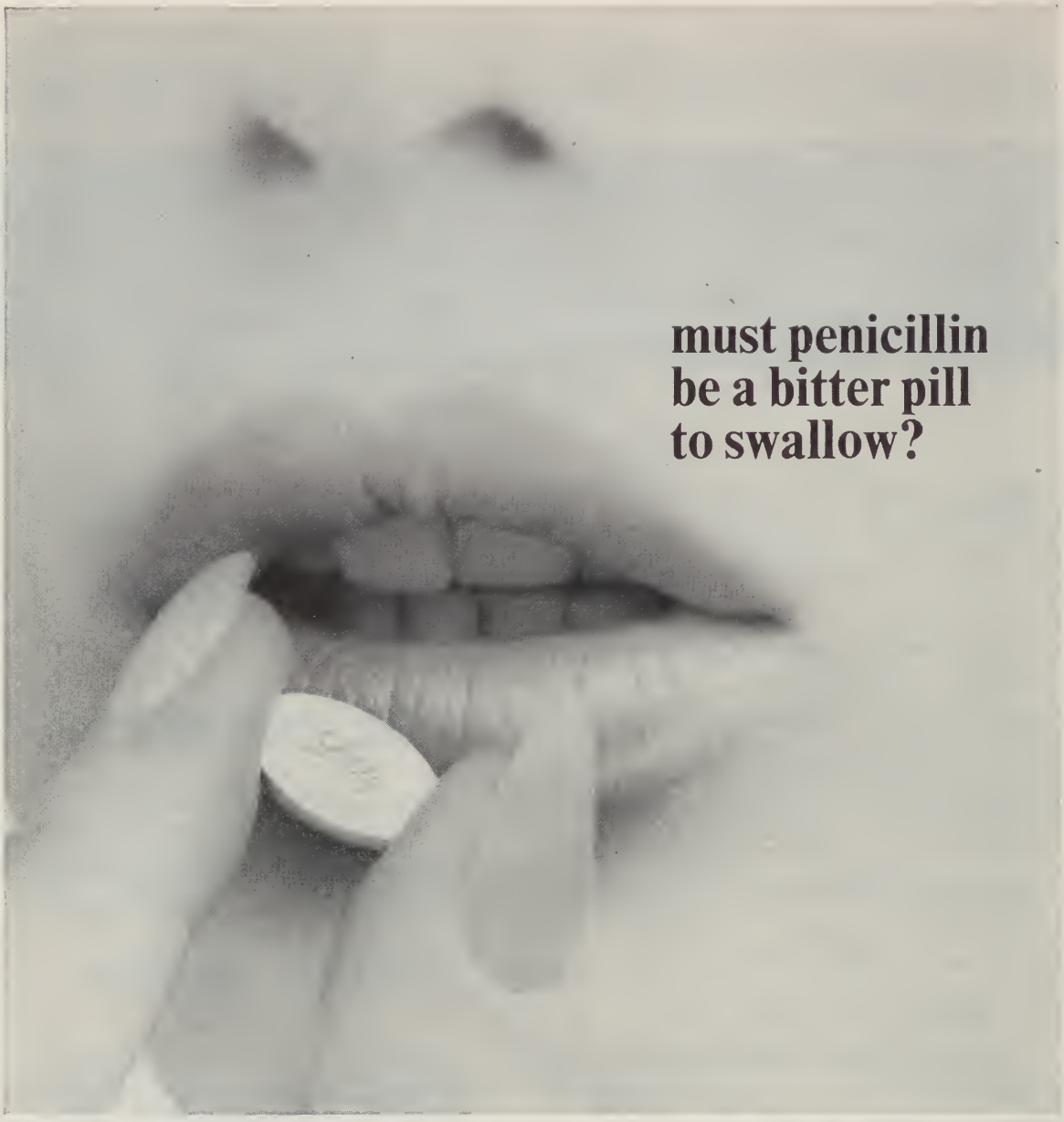
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Maryland State Medical Journal
Vol. 15, No. 6
June, 1966

Editorial

Crusaders Against Quackery

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

Is this a quote from proceedings of the American Medical Association's clinical convention in Philadelphia in December?

The meeting was in Philadelphia, but the year was 1847. From its very inception 118 years ago, the American Medical Association has been battling quackery and is dedicated to continue this warfare against wasting the nation's health and its health care dollar, of fighting fraud at the bedside of ill and desperate people.

As long as there are human beings, there will be human nature—and quacks, pretenders to ability they don't possess, to take advantage of the fact.

The health quack is not easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. Their space-age counterparts are suave, sophisticated-appearing super salesmen with the Madison Avenue manners. These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless cosmetic devices and treatments, worthless "cures" for everything —even for brain-damaged children and other mental illness.

They bilk the undiscerning, the uninformed, the desperate, the unsuspecting of all ages of millions of dollars a year. The estimates of the costs of medical quackery are at best calculated guesses, but they have gone as high as a billion dollars a year. One authority in the field of quack-fighting has said, "Medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life—and health—that has placed America's physicians in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself—the delay in proper medical care that may cost life itself. It is for this reason, too, that the medical profession is dedicated to educating people about cultism—chiropractic and the other health sects that turn their backs on scientific medicine.

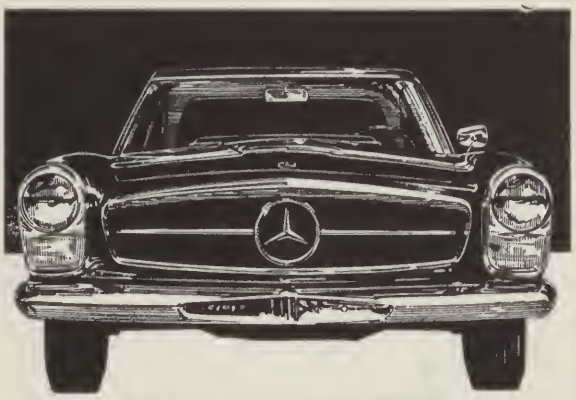
The House of Delegates of the American Medical Association said in 1933:

> Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong.

And in 1961, it said, "There can never be a majority party and a minority party in any science . . ."

After the quack or the cultist has extracted his pound of flesh, after the damage is done and the sick may have become the dying because of the delay in proper care, scientific medicine usually is called upon to pick up the pieces. Medicine has tried and will continue to try to do that job, too; but how much easier the job would have been, how many lives would have been saved, IF. . . .

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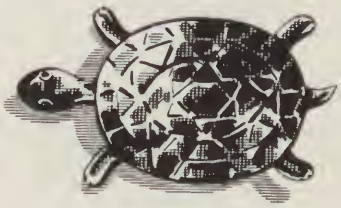


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EXECUTIVE SECRETARY'S NEWSLETTER

June, 1966

NEWS NOTES

Martin L. Singewald, M.D., Baltimore, has been elected the Maryland representative of the American College of Physicians.

New Maryland Society of Anesthesiologists Officers are: Walter Dandy, M.D., President; Martin I. Gold, M.D., President-elect; Harold Eccleston, M.D., Vice-president; Gerald Carroll, M.D., Secretary; and Albert Pats, M.D., Treasurer.

Henry N. Wagner, Jr., M.D., has been named President-elect of the American Federation for Clinical Research.

William K. C. Morgan, M.D., is new President of the Maryland Thoracic Society.

Harry M. Robinson, Jr., M.D., is the new President of the Maryland Dermatological Society with William R. Bundick, M.D., being named Secretary.

Robert T. Adkins, M.D., Salisbury, is the new President of the Heart Association of the Lower Eastern Shore.

MEDICARE REMINDER

With the advent of July 1, physicians will be seeing patients who are covered under Medicare, Title 18 of PL 89-97. If such physicians complete the Social Security form for payment for services rendered to patients under this program, they should be mailed to Blue Shield, the fiscal administrator for this program. For those beneficiaries who are covered under the Railroad Retirement program, such forms should be mailed to the local office of the Travelers Insurance Company, the fiscal administrator for Railroad Retirees and Dependents.

MORE INFORMATION

Persons formerly over 65 and covered under the Medical Assistance to the Aged program in Maryland may have purchased Part B of Title 18, PL 87-97. In such cases, their former MAA

card is no longer valid with respect to payments to physicians. Some persons, however, may not have purchased Part B, in which case the former MAA card still holds as does the payment schedule under this program.

PERSONALITIES

Isadore A. Siegel is the new President of the Maryland Obstetrical and Gynecological Society of Maryland.

REFERENCE COMMITTEE MEETING

The Reference Committee is scheduled to meet on

THURSDAY, JULY 28, 1966 at 8:00 p.m.

in the Faculty Building.

JULY 28, 1966

As of the writing of this Newsletter, the following resolutions have been received in the Faculty Office prior to the deadline date of July 15. Committees, members and Component Societies have until this date to submit resolutions for consideration at the Semiannual Session, September 9, 1966, in Ocean City.

Resolution 1S/66 - Changes in the Medical Practice Act to Permit Hospitals Associated with Medical Schools to Practice Medicine

Resolution 2S/66 - Liaison Committee to Screen All Requisition Forms of Maryland State Department of Health; Bureau of Laboratories; Insurance Companies; and Blue Cross and Blue Shield, so as to recommend Elimination of Unnecessary Detail

Resolution 3S/66 - The Medical & Chirurgical Faculty Request the State Health Department to Rescind its Action in Excluding the Practicing Physician's "Screening Activity" from Use of State Laboratory Facilities

John Sergeant

Executive Secretary

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Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

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JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, APRIL 14

1. The AMA is to be asked to reevaluate continued use of the TWX machine, as the number of messages sent and received is small and, proportionately, the cost per message high.

2. Faculty participation in the Albert E. Goldstein Memorial Fund was approved, provided that the Faculty's Program and Arrangements Committee has final approval with respect to presentation of any lectureship at any Faculty meetings.

3. Recommendations were made for gubernatorial appointments to the following boards and councils: Board of Physical Therapy Examiners, Advisory Council on Hospital Construction, and Advisory Board on Hospital Licensing.

4. Financial contributions were approved to the University of Maryland Chapter, Student AMA, and the Maryland League for Nursing.

5. Approval was given to mailing copies of the minutes of Executive Committee and Council meetings to the presidents of component societies.

COUNCIL, APRIL 26

1. 1966 dues were waived for a Baltimore City physician who is ill.

2. Emeritus membership is to be recommended for Robert Henin, MD, Baltimore County, and Simon Virkutis, MD, Dorchester County.

3. Physicians' defense was ratified for one member but denied to another member who paid his dues after the specified deadline.

COUNCIL, APRIL 29

1. Russell S. Fisher, MD, was elected Council chairman; J. Emmett Queen, MD, vice chairman.

2. A motion was adopted to appoint a committee to investigate and report to the Council reputed attempts of certain universities to discourage the entrance of medical students into general practice.

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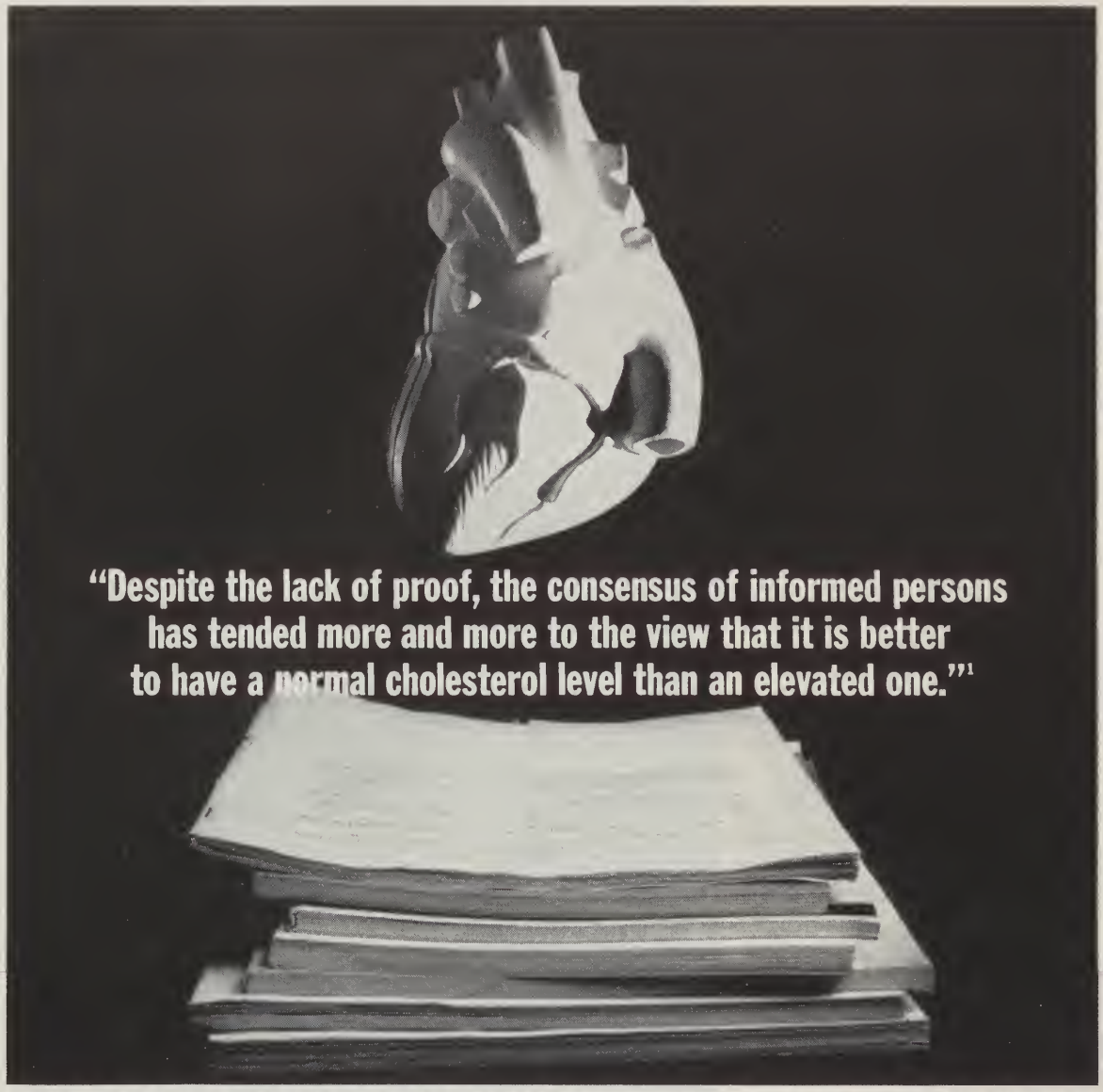
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Treatment of Hypertensive States

R. PATTERSON RUSSELL, MD

Who will benefit from treatment? In whom is treatment contraindicated? What therapeutic agents should be used?

I would like to emphasize, first, the importance of careful clinical evaluation and appropriate radiographic, blood, and urinary studies. If treatment is started before these studies are carried out, it becomes difficult to establish a diagnosis of primary hyperaldosteronism or pheochromocytoma. These basic studies provide not only a background for the diagnosis but also a point of reference as one treats the hypertensive patient over the ensuring years.

If we examine the distribution of blood pressure in the general population, two points emerge. There is a definite difference in the way the blood pressure is distributed, first with age and second between the sexes. The systolic and diastolic pressures rise with age in both sexes; the levels tend to be higher in females at any age. There also is a difference in the way the systolic and the diastolic pressures behave with age: the systolic rises much more sharply than the diastolic pressure.

With this in mind, let us consider whom to treat. To begin with, there are three rather urgent situations which require hospitalizing the patient: the malignant phase, hypertensive encephalopathy, and acute left ventricular failure.

We need only compare treated and untreated series of malignant hypertension to be convinced of this point the need to treat these conditions. Treatment has increased the survival figures from 10% to 60% one year after the diagnosis, and from 1% to 30% three years after diagnosis. Treatment must be instituted before renal function has been impaired if the patient is to derive the full beneficial effect of therapy. It behooves us, as physicians, to diagnose and treat malignant hypertension as early as possible.

Hypertensive encephalopathy is a unique situation which generally occurs when the blood pressure rises acutely. It is most commonly seen in acute nephritis, the malignant phase, or toxemia of pregnancy. Here again, the need for immediate therapy is obvious. The same may be said for acute left ventricular failure when it occurs in a setting of sustained hypertension.

More commonly, the physician must deal with patients who are beginning to show evidence of complications attributable to their high blood pressure. Target areas such as the eye grounds, heart, kidneys, and central nervous system must be carefully checked. As complications develop they are themselves indications for treatment.

Harvey Grant Beck Memorial Lecture, presented before the Medical and Chirurgical Faculty of the State of Maryland, April 23, 1965.

The appearance of retinopathy demands therapeutic intervention and may be the first warning of malignant hypertension. Chronic congestive heart failure, one of the commonest complications encountered by hypertensive patients, responds well to hypotensive therapy. With a history of coronary insufficiency or myocardial infarction, the approach is not as vigorous but is definitely warranted. Most patients with coronary insufficiency will respond to an effective lowering of the blood pressure without a worsening of their angina.

Renal impairment does not contraindicate hypotensive therapy, although it certainly demands a cautious approach. Abrupt lowering of the blood pressure in patients with renal insufficiency may worsen the situation. Most patients with cerebrovascular accidents tolerate blood pressure reduction, though in the elderly, the degree of reduction is smaller and must be attempted with more care lest the cerebral blood flow be further reduced and accompanied by a worsening of symptoms.

In some situations treatment is contraindicated, particularly in the patient who has gross mental deterioration and is unable to follow an effective therapeutic regimen. Toxemia of pregnancy begets concern for the survival of two individuals, the mother as well as the infant. Hence, the blood pressure levels that one selects to initiate treatment are considerably lower than in other hypertensive conditions.

The most vexing and by far the commonest problem that faces the clinician today is the hypertensive patient who has no complications whatsoever. Frequently, these patients are entirely asymptomatic. Sometimes they have symptoms such as lightheadedness, vertigo, tinnitus, fatigue, a sense of nervousness, or flushing sensation. But these are not of sufficient merit to warrant treatment. In the absence of complications, the level of blood pressure must at some point become an indication for therapy. Pickering has suggested that if at the ages listed, the diastolic pressure is persistently at or above the following levels, then therapy is indicated.

DIASTOLIC PRESSURES JUSTIFYING CHEMOTHERAPY

Age	*Male*	*Female*
under 40	105	115
40-49	115	120

These figures take into account the effect of age on the blood pressure and emphasize that hypertension is tolerated much better in women than in men. They are to be interpreted as a general guide and may be modified by a host of factors. In particular, therapy may be instituted at a lower level of blood pressure if there is a strong family history of hypertension with premature death, or if a patient begins to show signs of progressive vascular disease. If the blood pressure does not fulfill these criteria and it is decided to withhold therapy, the patient must be carefully watched for development of more significant hypertension or manifestations of complications which warrant therapy.

Just as it is important to know whom to treat, it is equally important to know whom not to treat. First are the young labile hypertensives without complications or symptoms whose blood pressure is in the range of 150-160 systolic over 90-100 diastolic. These patients deserve an initial evaluation which can serve as a baseline upon which they can be followed at six-month to yearly intervals. Evidence that these patients need to be started on therapy at this juncture is not convincing. The course of hypertension is so variable that it is impossible to predict who is going to develop complications. The situation should be explained to these young patients, and they should be followed regularly.

Another group comprises the elderly arteriosclerotic patients with predominantly systolic hypertension. These patients often do poorly on antihypertensive medications and sometimes get into a great deal of difficulty. A little sedation is generally effective, but if an antihypertensive medication is necessary, it should be a mild one. Gross mental deterioration from a cerebrovascular accident or other cause is generally a good contraindication for therapy. Finally, there are patients who, by reason of their employment, or personality, simply find it unacceptable or impractical to come to a doctor. These patients, if they do have sufficient indications for treatment, should be recommended for sympathectomy.

Having resolved the problem that therapy is necessary, what antihypertensive agents are available, and how are they employed? Table 1 groups the most commonly used antihypertensive drugs, explains their mode of action, and lists untoward side effects. Group 1 compounds are mild hypotensive drugs when used alone. They are also unique in the ease with which they may

TABLE 1

ANTIHYPERTENSIVE DRUGS

Group	Mode of Action	Untoward Effects
I		
A. Saluretic agents CHLOROTHIAZIDE (Diuril)	Initial effect due to decrease in intravascular volume. Mechanism of prolonged effect not understood.	Potassium depletion, hyperuricemia, gouty arthritis, hyperglycemia, thrombocytopenic purpura.
B. Rauwolfia preparations RESERPINE (Serpasil)	Depletion of catecholamine and serotonin in brain and of noradrenaline in blood vessels' walls, heart, and sympathetic ganglia.	Mental depression, nasal stuffiness, weight gain, bradycardia.
II		
A. ALPHA-METHYLDOPA (Aldomet)	"False - transmitter" effect depresses the level of sympathetic nervous function.	Drowsiness, dry mouth, depression, fever, impairment of liver function.
B. HYDRALAZINE (Apresoline)	Decreases total peripheral resistance through some peripheral action and increases cardiac output.	Headaches, tachycardia, palpitations. Syndrome clinically indistinguishable from acute disseminated lupus erythematosus.
C. MONAMINE OXIDASE INHIBITORS (Eutonyl)	Depressed sympathetic activity. Site of block not known.	Exogenously administered amines as are commonly found in cheese, beer, and broad beans may cause severe hypertensive reactions.
III		
A. Adrenergic blocking agents GUANETHEDINE SULFATE (Ismelin)	Interferes with the release or promotes the depletion of noradrenaline at the nerve endings.	Postural and exertional hypotension, congestive heart failure, nasal stuffiness, diarrhea, inhibition of ejaculation in males.
B. Ganglion blocking drugs MECAMYLAMINE (Inversine)	Competitive inhibition of acetylcholine at sympathetic and parasympathetic ganglia.	Postural and exertional hypotension, constipation, ileus, diarrhea, urinary retention, dryness of mouth, blurring of vision, impotence.
IV		
A. INTRAVENOUS TRIMETHAPHAN CAMSYLATE (Arfonad)	Same as ganglion blocking drugs.	Rapidity of action requires close monitoring, hypotension. All the side effects of ganglion blocking drugs when used beyond 24-48 hours.
B. PARENTERAL RESERPINE (Serpasil)	Same as rauwolfia preparations.	Postural hypotension, excessive sedation.

TABLE 2

PREFERENTIAL TREATMENT SCHEDULE

Clinical Condition	Drug of Choice	Usual Daily Dose Initial	Maintenance
Uncomplicated mild hypertension—(diastolic 110)	Chlorothiazide (Diuril)	0.5-1.0gm bid	0.25-0.5gm bid
Uncomplicated moderate hypertension—(diastolic 130)	Chlorothiazide (Diuril) and/or	0.5-1.0gm bid	0.25-0.5gm bid
	Reserpine (Serpasil) and/or	0.25mg tid weeks 1, 2, and 3	0.25mg qd thereafter
	Hydralazine (Apresoline)	5mg qid	25-50mg qid
Congestive heart failure	Chlorothiazide (Diuril) and/or	0.5-1.0gm bid	0.25-0.5gm bid
	Alpha-Methyldopa (Aldomet) and/or	250mg tid	250-750mg tid
	Reserpine (Serpasil)	0.25mg tid weeks 1, 2, and 3	0.25mg qd thereafter
Malignant hypertension or Failure of 1-3 to respond to treatment.	Guanethedine Sulfate (Ismelin) and	10-25mg qd	10-400mg qd
	Chlorothiazide (Diuril)	0.5-1.0gm bid	0.25-0.5gm bid
Encephalopathy	Intravenous Trimethaphan Camsylate (Arfonad) or	Approx. 4mg/min	
	Parenteral Reserpine (Serpasil)	0.5-2.5mg	

be combined with and potentiate the action of all compounds from Groups 2 and 3. Group 2 compounds are slightly more effective when used alone, are associated with more side effects, and are commonly combined with Group 1 but rarely with Group 3. Group 3 compounds are the most potent hypotensive drugs. These are associated with more extensive side effects, particularly postural hypertension. Group 4 compounds are administered parenterally or intravenously and preferably in the hospital, where the patient can be closely observed. While there is no set pattern for the treatment of hypertension, the physician who has mastered the use of one drug from each group will be prepared to lower effectively the blood pressure in most situations he encounters.

Successful treatment of hypertension requires individualization and flexibility. No one drug is effective for all patients, and a succession of regimens often must be tried before the most effective one is discovered. With few exceptions, treatment is usually initiated with the milder antihypertensive agents, such as chlorthiazide and reserpine. If the reduction in blood pressure is inadequate then other compounds may be added. Table 2 outlines the choice of drugs with the initial and maintenance dose in a variety of clinical situations.

In view of the frequency with which thiazide diuretics are prescribed in the treatment of hypertension today, it is well to be aware of their side effects. Hypokalemia, hyperuricemia, hyperglycemia, and thrombocytopenia have been reported after administration of the thiazide derivatives. The hyperuricemia rarely leads to attacks of gouty arthritis, and the hyperglycemia is a manifestation of impaired carbohydrate toler-

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ance. Most recently, a number of cases of circumferential, stenotic, ulcerating lesions of the small bowel have been reported in patients receiving enteric-coated potassium chloride alone or in combination with thiazide diuretics. When potassium is required, a diet containing potassium-rich foods should be considered first. If this is not sufficient, uncoated 0.3gm potassium chloride tablets or 10 to 20% solutions of potassium chloride should be used. Potassium combinations are potentially harmful and are probably not as effective as the solution or the uncoated and uncombined form in providing potassium for the patient.

In contrast to the more commonly used but less potent saluretic agents, adrenergic blocking drugs are the most effective and most potent compounds available today. Guanethedine is a long-acting drug, the use of which must be highly individualized. Postural hypotension is a natural but nevertheless limiting effect. Congestive heart failure may develop, apparently due to depletion of catecholamines from the myocardium. Nasal blockage, diarrhea, and inhibition of ejaculation in males are signs of unopposed parasympathetic activity.

In answer to the question, "Why do we treat?" many studies demonstrate an increased survival. In the benign forms of hypertension this is harder to document because of the time span over which the condition extends. In malignant hypertension there is, in addition to the improved survival, a regression of retinopathy, in many instances a reduction of heart size and return of the electrocardiogram toward normal, and a healing of the arteriolonecrotic lesions of the kidney.

In closing, it seems proper to consider the question of timing as to when treatment is instituted. In the acute situation, the patient should be hospitalized and the blood pressure immediately reduced. Diagnostic studies are delayed until the blood pressure is effectively controlled. In hypertension with and without complications, proper evaluation and diagnostic studies precede treatment and therapy is instituted only if the appropriate indications are present.

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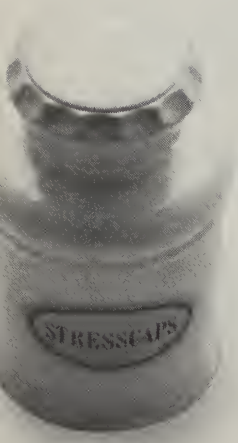
REFERENCE

Pickering, G. W., Cranston, W. I., and Pears, M. A.: The treatment of hypertension. Springfield, Illinois: Charles C. Thomas, 1961.



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Intravenous Regional Analgesia

Intravenous regional anesthesia was used in 17 cases involving surgery of the upper limb. It provided a satisfactory degree of anesthesia in 14 cases, failed in two cases, and required meperidene supplementation in one case.

PURIFICACION EZPELETA, MD
JOHN W. PEARSON, MD
JOSEPH S. REDDING, MD

In 1908, August Bier of Germany described his technique of "venous anesthesia" for the alleviation of pain in an extremity. He produced analgesia by expressing the blood from a limb by means of an Esmarch bandage, applying a tourniquet, and injecting a solution of local anesthetic agent into a vein. He was able to maintain analgesia for as long as two and a half hours.

Recently interest in this technique has been revised.[1,2] The principle involved in intravenous regional anesthesia of the extremity is the injection of a volume of dilute anesthetic solution into a vein after as much blood as possible has been expressed from the venous system and a tourniquet applied to prevent the inflow of arterial blood. The site of action of the anesthetic solution is uncertain. It may act proximally in the limb in the vasa nervorum or it may act by diffusing throughout all the tissues by retrograde flow through the veins.

A number of techniques are in use for producing satisfactory analgesia of an extremity by means of blocking peripheral nerves with local anesthetic solutions. Good results with these peripheral nerve blocks require the development of considerable skill and experience by the anesthetist. Consequently we were interested to learn whether equally satisfactory results might be obtained by less experienced persons using intravenous regional analgesia.

We would like to report a small preliminary series of 17 cases involving surgery of the upper limb. The anesthesias were performed by residents in training, so that our experience might be considered comparable to that of physicians in practice who undertake this procedure for the first time.

As in any situation where local anesthetics are to be injected in quantities approaching the upper limit of safe dosage, all necessary equipment for resuscitation was immediately available, a blood pressure cuff was applied, and an intravenous infusion was set up. An intravenous catheter was placed securely in a vein of the extremity to be anesthetized, and two tourniquets were placed as high up toward the axilla as possible but were not inflated. The whole extremity was drained of blood by wrapping tightly an Esmarch rubber bandage from the tips of the digits all the way up the extremity (Fig 1). The higher tourniquet was then inflated to approximately 250mm Hg pressure and the Esmarch bandage removed. After a delay of 5-10 minutes, 20 to 40ml of 0.5% lidocaine (about 1.5 mg/kg body weight) was injected through the catheter (Fig 2). Anesthesia usually occurred within five minutes. When it was evident that the anesthesia was complete and satisfactory, the catheter was removed from the vein. At this time the lower tourniquet was inflated and the higher tourniquet was released. The surgical field was then prepared for operation (Fig 3).

Of the 17 cases, 14 received an entirely satisfactory degree of anesthesia. There were two complete failures, and in one instance the anesthesia was described as being fair (intravenous meperiedine supplementation was necessary). In one of the two cases where anesthesia was unsatis-

From the Department of Anesthesiology, Baltimore City Hospitals.



Fig 1
Intravenous catheter in place. Blood being expressed from venous system preliminary to inflation of higher tourniquet.



Fig 2
Injection of 0.5% lidocaine after occlusion of arterial inflow.

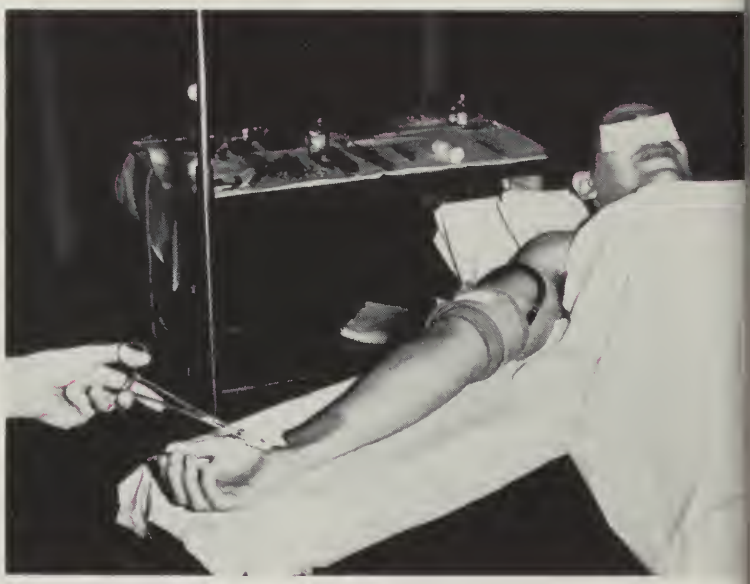


Fig 3
Preparation of surgical field after anesthesia has become established, lower tourniquet has been inflated, and higher tourniquet deflated.

factory the limb had not been well drained of blood before the tourniquet was inflated. This was in a patient who had a compound fracture of the wrist and it was not practical to apply the Esmarch bandage. In this case there was transitory anesthesia about two minutes after injection of the solution, but the anesthesia disappeared completely in the next three or four minutes. In the other unsatisfactory case there was a leak of one of the tourniquets, and although anesthesia had been achieved, the limb became flooded with blood and anesthesia disappeared. Thus strict attention to detail and careful checking of equipment are essential since the technique must be precise in order to insure success.

Anesthesia using this technique will last as long as the tourniquet is kept inflated. Full sensation returns within a few minutes after the tourniquet is released. Consequently the duration of anesthesia is limited to that period during which arterial inflow to the limb may be safely occluded. Two hours of tourniquet time is generally considered to be maximal. Discomfort from the tourniquet was a problem in only one patient. This absence of tourniquet pain was due to the use of a two tourniquet technique. The lower tourniquet was inflated only after anesthesia had been achieved distal to the higher tourniquet. In our cases the tourniquet was inflated for five to ten minutes before injection of the anesthetic mixture. Bell[2] reported most satisfactory results with a waiting period of 20 minutes between inflation of the tourniquet and injection of a local anesthetic solution. This long wait probably leads to considerable discomfort for the patient before the anesthetic is injected. Injection of a local anesthetic immediately after inflation of the tourniquet, on the other hand, leads to less profound anesthesia.

Total dosage of 0.5% lidocaine varied somewhat. Two patients received less than 25ml, four patients received 26-34ml, and 11 patients received 35-40ml. We were concerned at first that release of the tourniquet at the end of anesthesia might be accompanied by symptoms of toxicity because of the relatively sudden flooding of the vascular system with local anesthetic solution. Although the total dose of lidocaine would seem to be within the limits of safe dosage for infiltration purposes, a total of up to 200mg might well be unsafe if suddenly released into circulation. In this series we noted no changes suggestive of excitement or preconvulsive prodromata. The only changes which occurred on release of the anesthetic solution into circulation was a drop of 10mm Hg in systolic pressure in one patient after release of the tourniquet; four patients showed a decrease of pulse rate by 5-10 beats/minute. All other patients showed no signs that could be related to the local anesthetic solution.

The advantages and disadvantages of this method should be considered in deciding whether the technique deserves to be revived. Among the advantages of the technique are the following: little manual dexterity is necessary for its performance, since it can be achieved by anyone capable of making a venipuncture. No direct trauma to nerves is involved. There is no danger of puncture of the lung for anesthesia of the upper extremity. Recovery from the anesthesia is quick, so that the surgeon can be satisfied early of the results of his repair of tendons, and the patient can be of assistance in indicating any untoward symptoms.

The two disadvantages of the technique are most obvious. The first is that the duration of anesthesia is limited by the time which the surgeon and anesthesiologist deem prudent to keep the tourniquet inflated. Second, in patients with painful injuries of the extremity, the use of the Esmarch bandage causes considerable discomfort or may be impossible. Anesthesia is unsatisfactory without the Esmarch bandage.

We conclude that intravenous regional anesthesia is a safe and simple method for producing anesthesia of an extremity without the need for special training or great skill; however, it does require strict attention to detail. It is particularly useful for short procedures where a bloodless field for the surgeon is a requirement. It is probably not the anesthesia of choice when the surgical procedure will be protracted, when a tourniquet is undesirable, and when there is a fracture or other painful condition of the limb. This method of regional analgesia is a complement to axillary or supraclavicular block; not a substitute.

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A New Rapid Serologic Screening Test for Syphilis

In an evaluation of 10,279 samples of either serum or plasma employing the Pallada-Test Antigen, there was 100% agreement in comparison with the classical VDRL microflocculation test. The new technique has the advantages that: 1) the antigen is stable; 2) it can be used with either serum or plasma; 3) the sample does not require heat inactivation; 4) reaction can be observed macroscopically. Additionally, the antigen is inexpensive. It is sensitive and allows single or multiple tests to be performed in a matter of a few minutes. As such, this technique is particularly adaptable for prescreening of donors for blood banks, for rapid screening in outpatient clinics, for use in small laboratories, and as an office test in the rapid diagnosis of suspected cases of syphilis.

JOHN E. STAUCH, PhD

WARREN W. KOPP, BS

Because of the increase in the infection rate of syphilis, interest has been renewed in methods for the early detection of such infections. Demonstration of the treponeme in a chancre by dark-field microscopy would afford enough evidence so that therapy could be initiated; but, unfortunately, too many patients ignore the presence of a "sore" or wait too long to seek medical attention, and the treponeme cannot be demonstrated. Diagnosis must then depend upon serologic means.

Classical serologic methods require precise technology. Either because of technical difficulties, as in the complement-fixation tests, or because of the instability of the antigens, as in the flocculation tests, most small laboratories do not perform serologic tests for syphilis. A test designed to meet the needs of the smaller laboratories or for use in office practice would be of value. Such a test should: 1) be performed with ease, 2) not require special tools or apparatus, 3) be inexpensive, 4) be designed so that single or multiple tests may be performed in minutes at any time, 5) employ a stable antigen, and 6) be as sensitive and specific as any of the classical antigens in use. The results of this study demonstrate that the proposed technique and antigen under study satisfies the established criteria.

Materials and Methods

The antigen used in this technique is made from a previously approved lot of cardiolipin-lecithin-cholesterol complex. These are prepared in accordance with the procedures developed by Pangborn et al.[1] The raw antigen solution was furnished by the Sylvana Company. Each lot is serologically standardized by comparison with a standard antigen of known reactivity. The unique feature of this antigen is that it is the VDRL antigen tagged to an inert carrier to allow macroscopic observation. Also, the antigen has been

From Laboratory Services, USAF Hospital Andrews, Andrews Air Force Base.

The Pallada-Test Antigen was supplied by the Bio-analytical Products Laboratory, Inc., Suitland, Md.

stabilized and made anticomplementary. Therefore, either plasma or sera may be employed in the test. These do not require heat inactivation, although samples previously heat inactivated can be tested. This antigen is stable for at least six months at refrigeration temperature and at least three months at room temperature. Each lot of the tagged antigen is serologically compared with standardized antigens and antisera.

The samples employed for the evaluation of the tagged antigen were obtained from: 1) random samples submitted for various chemical procedures, 2) prenatal samples submitted for serologic testing, 3) physical examination samples submitted for serologic testing, 4) samples submitted from suspect cases of syphilis, and 5) samples submitted by the Maryland State Health Department for serologic evaluation.

The tagged antigen was compared to the classical VDRL microflocculation procedure.[2] The sera found reactive to the tagged antigen or the VDRL microflocculation procedure, or both, were tested with the Reiter Protein Complement Fixation (RPCF) test[3] and by the Fluorescent Treponemal Antibody (FTA) test.[4]

The tagged antigen procedure was performed as recommended by the manufacturer. Either plasma or sera were obtained from venous blood or capillary blood (microhematocrit tubes, plain or heparinized). The clotted or whole blood samples were centrifuged gently to obtain clear plasma or sera. Using the Dispopette (Scientific Products), one drop of the patient's sample was placed either in the well of a Boener slide or of the slide furnished with the set. Positive control sera of known reactivity (Dade Reagents, Inc.), negative control sera, and weakly reactive control sera were similarly placed in the wells of a slide.

Samples collected in microhematocrit tubes were centrifuged in the microhematocrit centrifuge for one minute or were allowed to stand vertically in critoseal until the cells settled. The tubes were scratched at the interface of the plasma and cells. The tube was gently broken and a drop of the sample placed on the slide. The antigen was shaken to obtain an even dispersion of particles, and one drop was added to each of the test samples and the control samples. The contents of each well were mixed with an applicator stick, and the slide was rotated either on the mechanical rotator at 180 rpm for four minutes or by hand for four minutes. Both methods were equally satisfactory. When large numbers of tests were run, it was more convenient to use the mechanical rotator; when only a few were tested, rotation by hand was more convenient.

The results of the procedure were obtained by viewing the samples using soft oblique light through a blue filter of the microscope lamp. The positive controls and the reactive sera showed large clumps of the antigen-antibody complex. Negative reactors showed no clumping, and weak reactors were easily detected by comparison to the negative control. Reactive samples were titered by serial dilution of the sample in phosphate buffered saline diluent, and each dilution was tested as above.

Results

Accordingly, 10,279 samples of serum or plasma were tested by the tagged antigen and the classical VDRL microflocculation procedure. The results of the testing were classified as either negative or reactive. No attempts were made to grade the degree of reactivity except that all reactive samples were titered using the standard serial dilution method. Table 1 depicts the results of the two screening procedures and shows 100% correlation between the two methods.

Among the reactive samples, only those of clinical importance were titered. Table 2 reflects the results of this study. The end point was considered when the test reaction was just different from the negative control. It can be seen that 70 of the samples gave positive titers by the tagged antigen while 68 were positive by the VDRL microflocculation. The titers were slightly higher with the tagged antigen than with the VDRL microflocculation.

Three samples demonstrated a prozone reaction. They were considered weakly reactive by both the tagged antigen and the VDRL microflocculation, but upon titering the samples, one had a titer of 1:128 and two had titers of 1:64.

All reactive sera, in addition to titering, were tested with the RPCF test and the FTA test. Of the 110 samples so tested, only 63 were positive. The two treponemal tests were in 100% agreement and reflected that although both screening tests were in agreement, they were capable of elaborating false positive reactions. On further examination of the results, it was noted that all 63 positive by the RPCF test and FTA test were among those samples which had positive titers by

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Duodenal mucosa with ulcer crater—
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Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

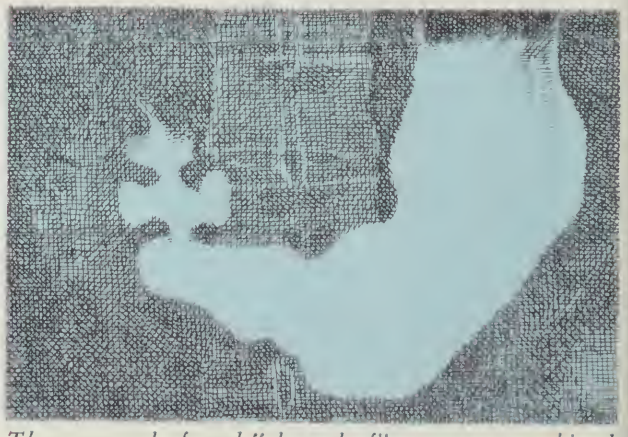
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

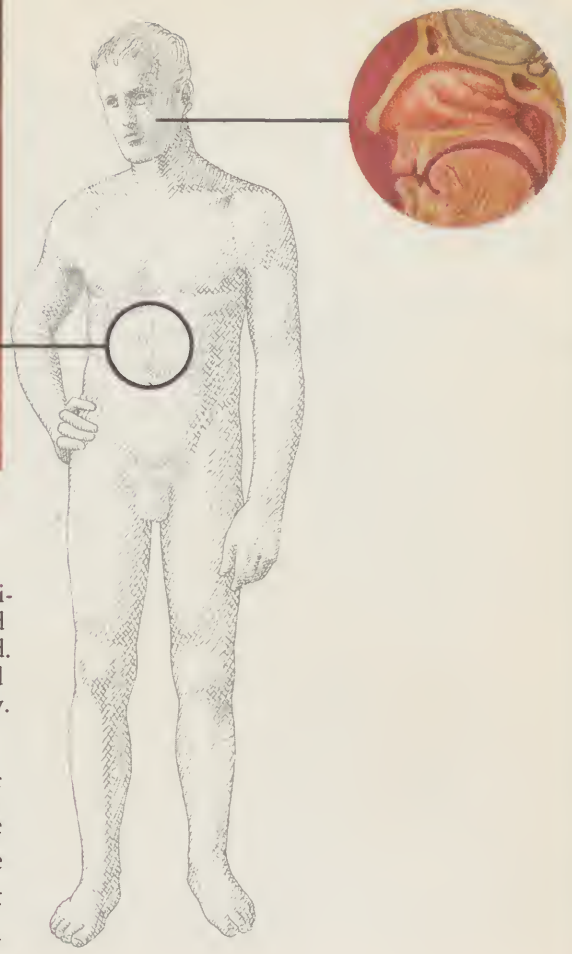
The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.





Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

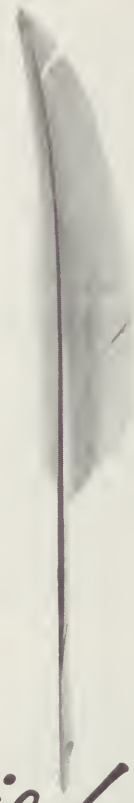
Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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Table 1
Correlation of the Tagged Antigen with the VDRL Microflocculation Test in Elaboration of Reactive Sera

Sample	Tagged Antigen		VDRL Microflocculation	
	Negative	Reactive	Negative	Reactive
Random	4601	8	4601	8
Pre-Natal	1410	18	1410	18
Physical Exam.	3800	6	3800	6
Suspect Syphilis	140	78	140	78
Dept. Health (Md.)	100	100	100	100

Table 2
Correlation of the Tagged Antigen with the VDRL Microflocculation Test in Titering of 110 Reactive Sera

Titer	None	1:2	1:4	1:8	1:16	1:32	1:64	1:128
Tagged Antigen	40	4	10	22	24	6	2	2
VDRL Microflocculation	42	2	14	24	20	4	2	2

the tagged antigen and VDRL microflocculation test. Most of the false positive reactions occurred among the group of prenatal tests. False positive reactions were determined by two methods. The first was that the sera failed to show a rise in titer to the screening tests on subsequent testing or they became negative without the intervention with therapy, and they were negative to the treponemal antigens.

Discussion

The results of this study demonstrate that the new procedure makes an excellent screening test, but, like all other such tests which measure "reagin," a more specific test is required to elaborate true cases of syphilis. Several treponemal antigen tests can be employed, two of which were used in this study. In our experience, antibody to the treponemal antigens appears after the presence of reagin; hence early cases of syphilis may demonstrate reagin but not antibody to the treponeme. Therefore, clinical judgment along with the history is important in management of patients that reflect positive screening tests that have no titer and are negative to treponemal tests.

Although it is recommended that reactive sera be tested with treponemal antigens, few laboratories engage in the tests because of their complexity and the expensive equipment required. We investigated the possibility of using the protein extract of the Reiter strain of treponeme tagged to the carrier employed in the Pallada-Test Antigen. A simplified procedure has been devised for the demonstration of antibody to this treponemal antigen, but the evaluation of this procedure has not been completed.

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MALIGNANT TUMORS OF THE TONSIL

The clinical management of 66 cases of malignant tumors involving the lateral pharyngeal wall is described. The results of therapy correlated with the stage of disease and method of treatment are presented. In Stage I disease, irradiation or surgical excision resulted in an 80% three-year survival rate. Moderately advanced tumors were associated with a 25-30% three-year survival rate with either means of therapy. There were no survivors in patients with far advanced disease.

R. ROBINSON BAKER, MD
JOHN HOOPES, MD
JERRIE CHERRY, MD
STEWART LOTT, MD

This report is based on the clinical experience gained in the management of 66 cases of malignant tumors involving the pallatine tonsil or tonsillar fossa.[1] These tumors account for approximately 20% of malignancies arising in the oral cavity. The disease is relatively uncommon and frequently not recognized as a neoplasm in its early stages of development.

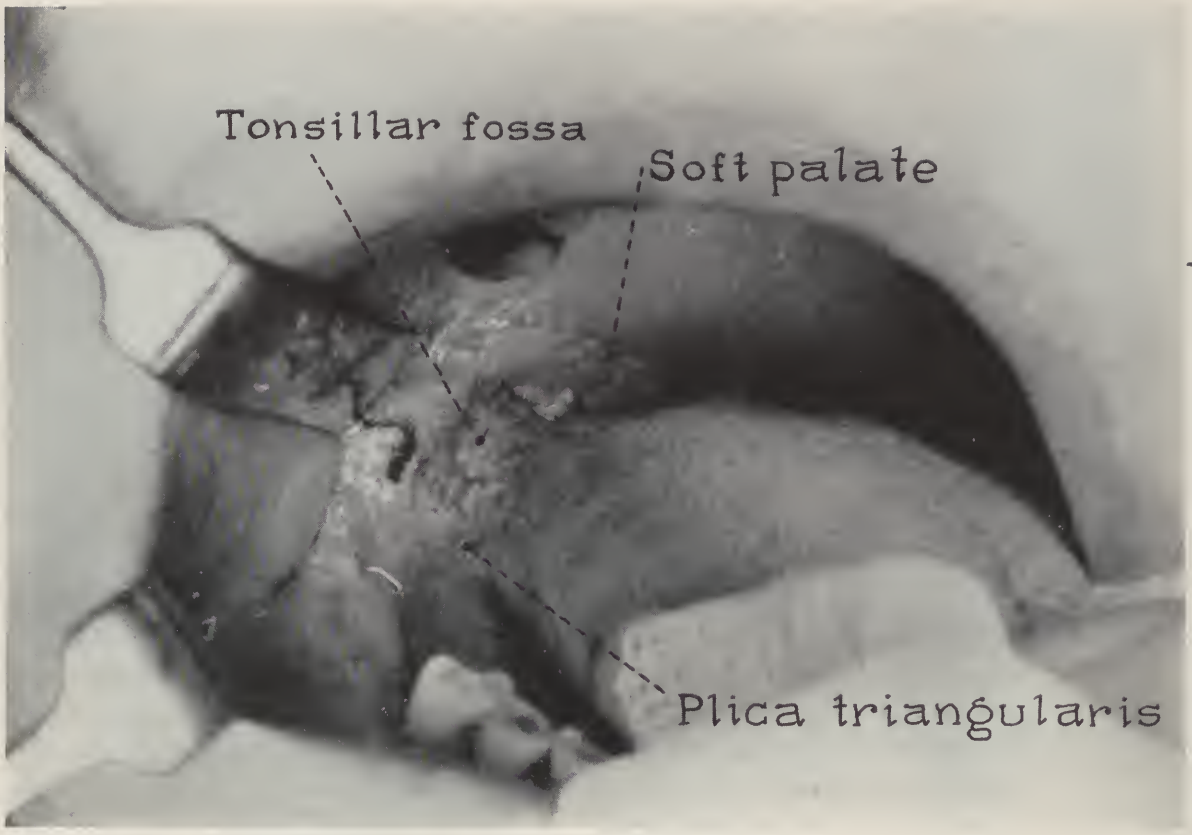
ANALYSIS OF CASES

Histology.—Ninety per cent of malignant tumors arising in this anatomical area were of squamous cell origin. The remaining tumors were various types of lymphomas including lymphoepithelioma, follicular lymphoblastoma, and lymphosarcoma. Seventy-two per cent of the patients with squamous cell carcinomas developed cervical lymph node metastases at some time during the course of the disease. This was probably the result of a combination of the biologic behavior of the tumor and the rich lymphatic network draining this anatomical area.

Clinical Material.—Carcinoma of the tonsil is encountered most commonly during the fifth decade of life, followed by the sixth and seventh decades. The ratio of male to female patients in this series was approximately three to one. Thirty per cent of the patients were chronic alcoholics, and more than half of the patients gave a history of heavy cigarette smoking. A sore throat or the detection of a mass in the neck were the most common presenting symptoms.

Early tumors can present as innocuous-appearing lesions, and a high index of suspicion is necessary for a correct diagnosis. The diagnosis should be considered whenever the tonsil is swollen or small whitish plaques are present over its

From the Department of Surgery, Division of Plastic Surgery, Department of Otolaryngology, and Division of Radiotherapy, The Johns Hopkins University School of Medicine.



mucosal surface. The typical squamous cell carcinoma presents as an ulcerative lesion (Fig 1). In contrast, lymphomas characteristically present as a tonsillar mass without ulceration of the overlying mucosa. The neck should be examined for palpable nodes in all suspected cases of tonsillar carcinoma. Metastatic nodes usually present at the angle of the mandible along the course of the internal jugular vein.

Cytologic smears have proven to be a useful method of screening suspicious mucosal lesions. Biopsy is easily accomplished without significant morbidity. Bilateral tumors[3] occur in approximately 10% of the cases, and the contralateral tonsil or tonsillar fossa should be biopsied prior to definitive therapy.

A method of clinical staging has been proposed by the Joint Committee of the American College of Surgeons.[4] This system of staging describes the lesion by three parameters: 1) T—the anatomical extent of the primary tumor; 2) N—the presence or absence of cervical lymph nodes; and 3) M—the presence or absence of distant metastases. On the basis of this TNM classification, the cases are divided into four stages (Table 1).

TREATMENT

Operative treatment consisted of a radical neck dissection in continuity with a partial mandibulectomy and excision of the primary tumor. Reconstruction of the oral cavity was accomplished by a variety of techniques: 1) primary closure, 2) tantulum supported skin grafts, and 3) local tongue flaps.

Table 1

Clinical Staging according to the American Joint Committee's Proposed Method of Stage Classification[4]

Clinical Staging	
Stage	No. of Cases
I	10
II	13
III	28
IV	10

Fig 1

quamous cell carcinoma arising in the right ton-llar fossa with extension to the soft palate and ica triangularis.

Those cases undergoing irradiation before 1960 were treated by orthovoltage x-ray utilizing 250 kv (HVL-2mm cu). Patients treated since then have received supravoltage x-ray therapy delivered by means of a 2 Mev. Van de Graaf generator (HVL-6.5mm Pb). Seven patients in this series received a planned course of preoperative x-ray therapy.

RESULTS OF THERAPY

Squamous Cell Carcinoma.—The results of the various types of therapy correlated with the stage of the disease are presented in Table 2. Stage I disease carries a relatively good prognosis. Results of Stage II and Stage III disease are essentially the same, regardless of treatment. There were no three-year survivors with Stage IV disease. In this series, the use of preoperative x-ray as an adjuvant to surgical excision did not increase the survival rate obtainable with either radiotherapy or surgery alone.

Lymphomas. — One patient with a follicular lymphoblastoma survived three years. The remaining patients with other types of lymphoma died with generalized disease within four to 21 months after initial therapy. All of these patients were treated by irradiation.

DISCUSSION

An analysis of this group of cases stresses the importance of early diagnosis. Tonsillar car-

Table 2

Results of therapy correlated with stage of disease—Squamous cell carcinoma

Stage I

Treatment	No. of Cases	3 Yr. Surv.	%
Irradiation	4	3	75
Composite Resection	5	4	80
Local Excisions	1	1	100

Stage II

Treatment	No. of Cases	3 Yr. Surv.	%
Irradiation	3	1	33
Composite Resection	8	2	25
Pre-op. Irrad. & Composite	1	1	100
Irradiation and Rad. Neck	1	1	100

(1 patient died before treatment was started)

Stage III

Treatment	No. of Cases	3 Yr. Surv.	%
*Irradiation	13	3	33
Composite Resection	8	2	25
Pre-op. Irrad. & Composite	6	1	16
Local Excision & Rad. Neck	1	1	100

Stage IV

Treatment	No. of Cases	3 Yr. Surv.	%
Irradiation	8	0	0
Composite Resection	2	0	0

* Three patients treated by irradiation died of unrelated disease and were not included in the calculation of the three-year survival rate.



A

Fig 2

A. Approach to carcinoma of the tonsillar pillar and buccal mucosa through a face-lifting incision. The forehead flap is outlined with dye.

B. Postoperative result following construction of the forehead flap. The resulting defect has been covered by a split thickness skin graft.

cinoma can be cured if diagnosed early in the course of the disease. A distressing number of patients in this series were treated for inflammatory conditions, thus delaying diagnosis and appropriate therapy.

Surgical excision or radiotherapy appear to be equally effective in the management of tonsillar carcinoma. However, radical surgical excision of the tonsillar area was associated with an operative mortality of 13% in this series. Two of these deaths occurred from hemorrhage in the immediate post-operative period. The remaining two patients developed oral cutaneous fistulae which resulted in exposure of the carotid artery. Death occurred from hemorrhage secondary to infection and subsequent necrosis of the arterial wall. Although these deaths occurred within the early years of this study, hemorrhage will always remain as a potential cause of death in any operative procedure. The deaths from oral cutaneous fistulae can be prevented by improved methods of closure. Within the past several years, an improved technique of reconstruction has been developed which utilizes a large forehead flap based on the ipsilateral superficial temporal artery[2] (Fig 2). This type of repair provides an excellent means of covering large mucosal defects, but it does not replace the intricate musculature which is necessary for normal swallowing.

There was no significant difference in the immediate morbidity associated with surgical excision or irradiation. Dysphagia was a significant long-term complication in those cases treated by radical surgical excision. This was attributed to resection of the musculature of the lateral pharyngeal wall.

On the basis of this relatively small number of cases, it is difficult to establish the optimal means of cure or effective palliation. The recent advances in surgical technique may lessen the operative mortality and morbidity. In an effort to answer these questions, we are initiating a controlled study. In a random series of patients, the effectiveness of irradiation of the primary tumor fol-



B

lowed by a radical neck dissection will be compared to the operative procedure which removes the primary tumor in continuity with a radical neck dissection.

The therapy of patients with tonsillar carcinoma usually does not end with the initial treatment to the primary tumor and the cervical metastasis. A constant number of recurrences are encountered which present an even greater challenge in management. The treatment of recurrent disease in this series of patients has also been analyzed. Surgical excision offers the best chance of salvage following recurrence of lesions initially treated by radiotherapy. The results do not appear to be affected by the time interval between initial therapy and detection of the recurrence. Recurrent disease following an operative procedure has been controlled for significant periods of time by either radiotherapy or simple local excision. The time interval between the operative procedure and the detection of recurrence in this group of patients seems to be important. Those patients developing a recurrence within 12 months of the operative procedure did not benefit from additional therapy of any kind.

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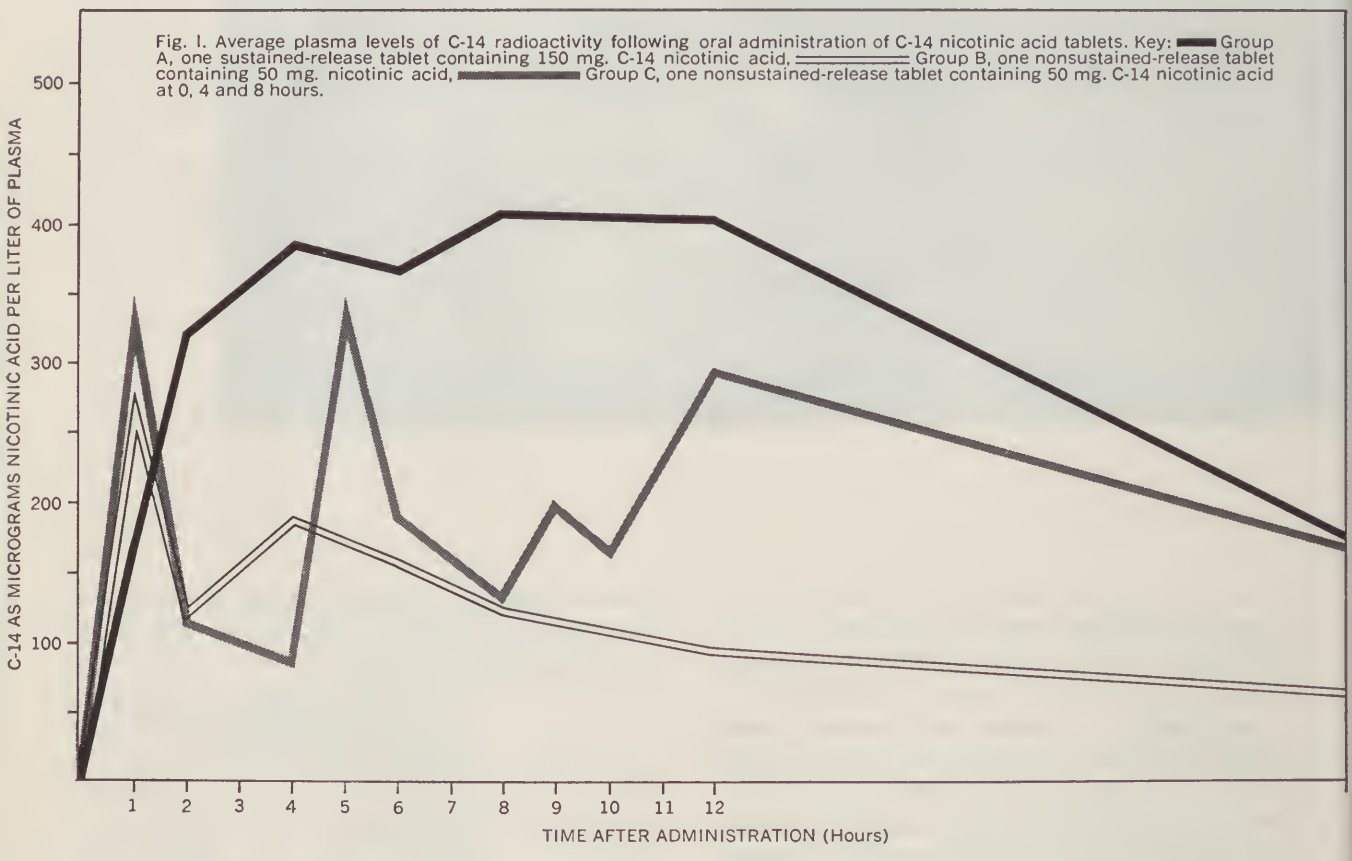
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(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

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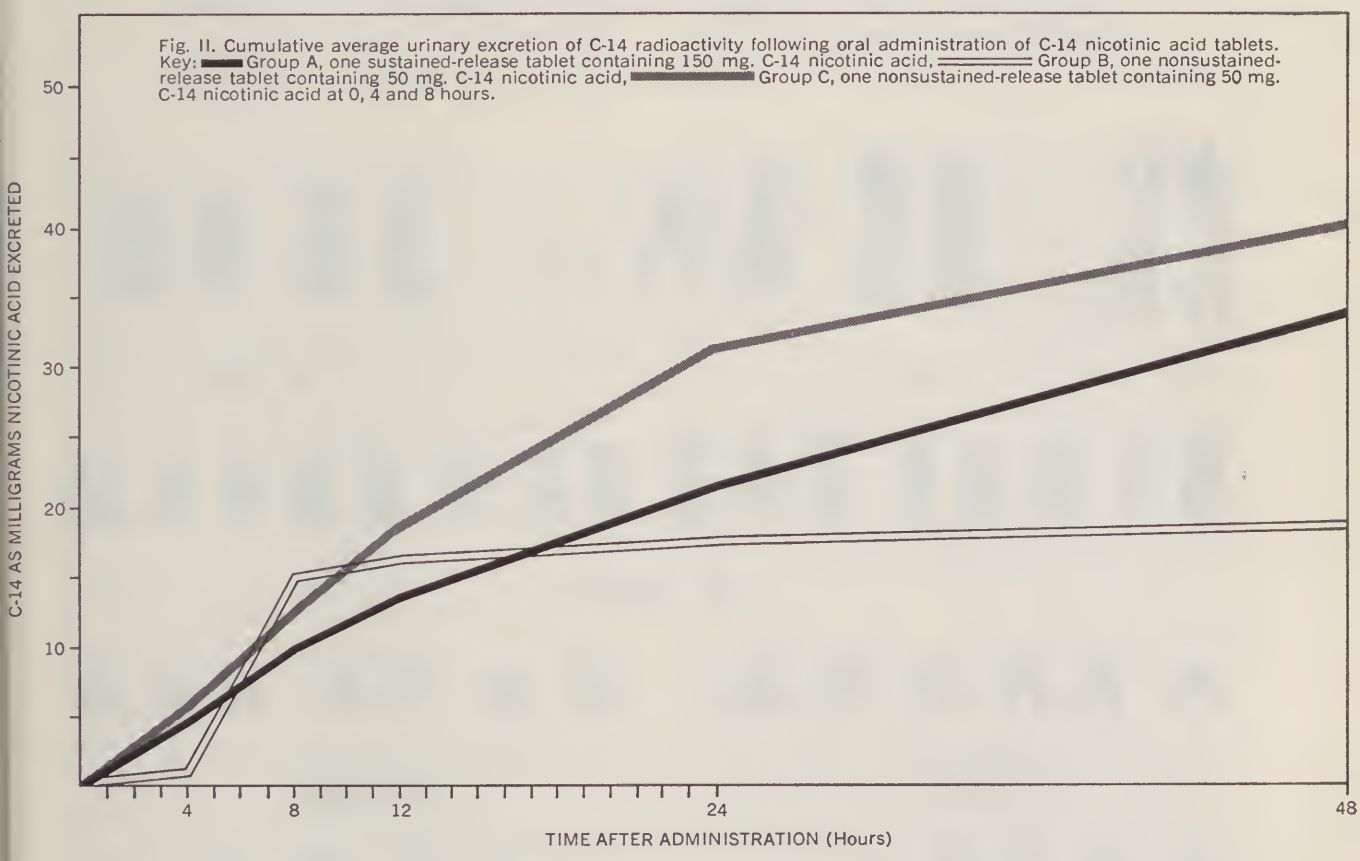


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

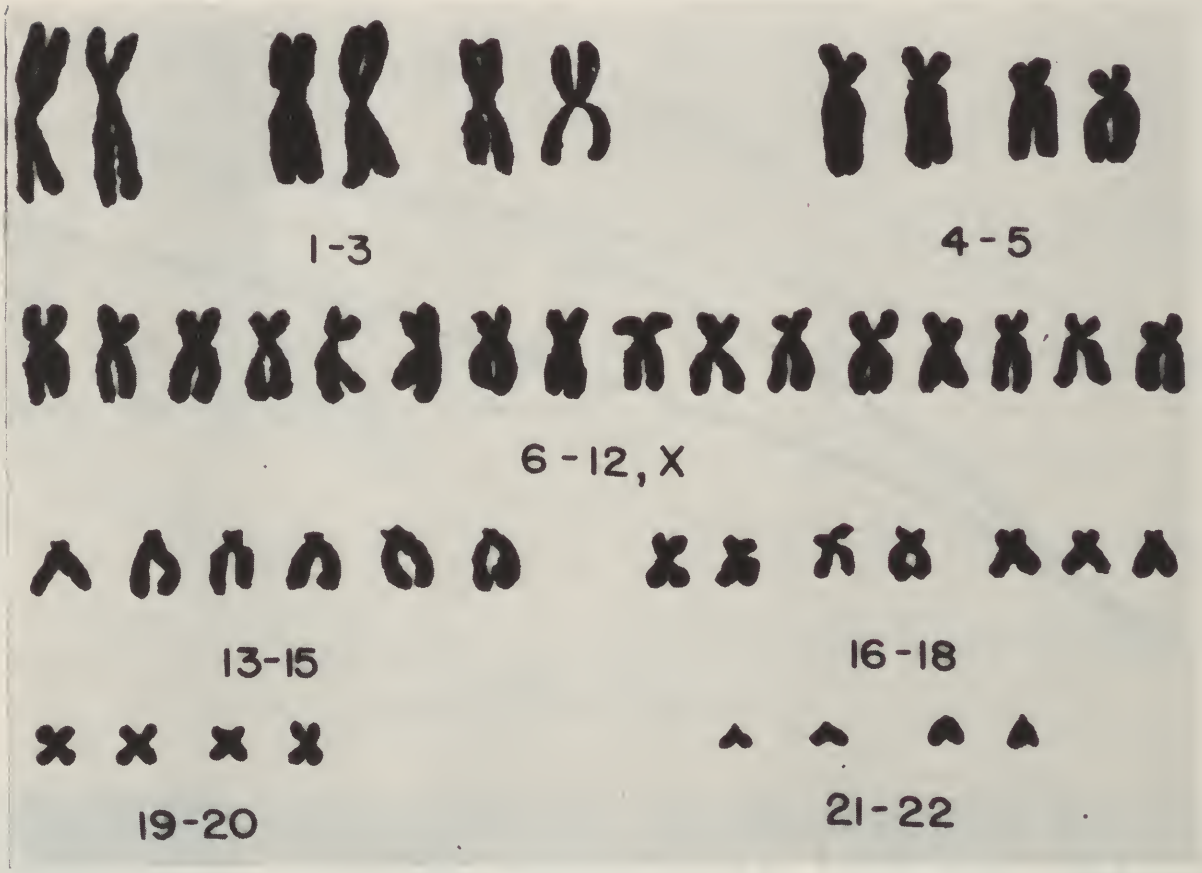
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A case of trisomy 17-18 and a review of the literature is presented. This chromosomal anomaly is associated with an exceedingly large number of congenital defects. Low-set malformed ears, receding chins, flexed fingers, and intraventricular septal defects are the only relatively common abnormalities. None of these is specific for the syndrome. Female births predominate. There is a strong tendency to post-term delivery. Advanced maternal age seems to be the only apparent causative factor. The inconsistency of the clinical findings makes chromosomal analysis mandatory. The prognosis is poor.



Karyogram

TRISOMY 17-18

The Clinical Scope of a Chromosomal Aberration

HANS-DIETER TAUBERT, MD
ERICA F. MOSZKOWSKI, MD
OAKLEY H. SAUNDERS, MD

The human chromosomal complement had been definitely established as 46 in 1956.[34,58] It was soon recognized that certain numerical and structural deviations from the normal state need not necessarily be lethal. Several congenital syndromes of varying degrees of severity have consistently been found in association with such aberrations.

The concurrence of abnormal karyotypes with relatively well defined clinical entities as Down's, Turner's, and Klinefelter's syndrome and the trisomies involving the chromosomes 13-15 and 17-18 raised some hope that chromosomal aberrations would serve as denominator for accurate classification of the wide range of congenital defects observed.[5,35,44,45,50] As more cases were reported it became apparent that each chromosomal anomaly could be associated with a surprisingly large number of congenital defects. Only few would be found frequently enough to consider them as pathognomonic. Many seem to be common to all autosomal abnormalities. Healthy individuals with obviously abnormal karyograms have been observed.[38,56,60] Conversely, normal chromosomal analyses have been obtained from patients who were believed to exhibit the typical features of a given syndrome.[3,46,48]

The frequent lack of correlation between morphologic defects and cytologic data points out the necessity of reporting further case material. This might contribute to mapping chromosomes as to areas where they cause defects[22] and to elucidating possible etiologic and epidemiologic factors. We had the opportunity to study a newborn with the features of trisomy 17-18. This case stimulated a review of the literature, which will be presented.

Case Report

The patient, a Negro girl, was born on September 2, 1963. The pregnancy and delivery had been uneventful. No placental abnormality was noted. The gestational age was 45 weeks according to the last menstrual period.

The mother was 44 years old, and the father was 54. There were eight previous children, of which one was stillborn at 32 weeks of gestation.

There was no evidence of consanguinity or congenital malformations in the family. Neither parent had been exposed to irradiation or febrile illness around the time of conception. The mother's hematogram was normal. Several unusual features presented at birth. The infant weighed 2125 gm. The suboccipito-bregmatic circumference measured 33cm; the thorax, 28cm; and the crown-to-heel length was 47.5cm. The cry was good. Muscle tone was poor. The ears were small and pointed. The uppermost portion of the helix was at a level with the outer canthus of the eyes. The eyes were normal, including fundoscopic examination. The occiput was of questionable prominence. A harsh, pansystolic murmur grade iii/iv was best heard in the third intercostal space right of the parasternal line. The lateral aspects of the extremities showed hypertrichosis and lichenification. The flexion crease of both digiti minimi was absent. There was some degree of gull-wing deformity of the left hand. Both feet showed "rocker-bottom" formation.

Laboratory data: Hematologic and chemical blood analyses were normal. Chest x-ray showed general enlargement of the heart, more marked on the left. Electrocardiogram revealed sinus tachycardia and right axis deviation. On the basis of the presenting anomalies, the clinical diagnosis of trisomy 17-18 was entertained. Barr bodies were seen in 43% of the cells obtained by buccal smear.

Leukocytes were cultured by modification of the technique of Moorhead et al.[47] Sixty-two cells in metaphase were used for analysis. The chromosome count in all but two was 47 (Table 1). Karyograms were constructed from 17 metaphase preparations with 47 chromosomes and from both cells with 46 chromosomes. In the former group an extra autosome with submedian centromere similar to the chromosomes 17-18[32] or group E[51]

Table 1

Number of Chromosomes	45	46	47	48
Number of Cells	0	2	60	0

From the Department of Obstetrics and Gynecology, University of Maryland School of Medicine; and the Department of Pediatrics, Provident Hospital, Baltimore.

was found. These supernumerary chromosomes were not present in the two cells with normal chromosomal number of 46 (Fig).

Chromosome counts of less than 46 were not encountered. No attempt was made to attach numbers to the chromosomes 6-12 (C) and 13-15 (D). The X-chromosome was included into group 6-12. The trisomic autosome was labelled as 17-18.

Clinical Course: The infant remained sluggish and inactive. She fed and gained weight poorly. She was discharged at four weeks of age. She was readmitted to the hospital on January 26, 1964, dehydrated and in cardiac failure. She died the next morning at 19 weeks.

Postmortem examination: The body of this undernourished and dehydrated Negro infant weighed 2150gm and measured 53cm in length. There was almost complete loss of subcutaneous fat tissue. The external genitalia had normal female appearance. The fourth and fifth finger showed fixation of the interphalangeal joints between the proximal and second phalangeal bone. The plantar arches were bilaterally flattened.

The foramen ovale was closed. Both ventricular walls were hypertrophied. A large interventricular defect of 0.7cm was present. There was no coarctation of the aorta. All cardiac valves were of normal configuration. The lungs showed many circumscribed dark reddish areas. The thymus weighed 2gm; the cut surface showed a marked increase of fibrous tissue between yellowish lobules.

Microscopic examination: Many pulmonary alveoli contained neutrophilic leukocytes and macrophages with vacuolated cytoplasm; others contained red blood cells. The alveolar epithelium was hyperplastic. Edema and interstitial pneumonitis were present.

Sections of the liver revealed acute congestion. Examination of the salivary glands failed to show intracytoplasmatic or intranuclear inclusion bodies. There was atrophy of the adrenals with lipid depletion. The convoluted tubules of the kidneys showed cloudy swelling. The cortex of the thymus contained a smaller number of thymocytes than normal.

Review of the literature

During a review of the literature up to the end of 1963 we encountered 30 communications containing data on 55 cases.[1-30]

The significant symptoms, anomalies, and observations were tabulated and listed with reference to the respective authors.* It soon became apparent that the enormous diversity of findings stood in sharp contrast to the relative paucity of defects which one could consider specific for this syndrome.

Affected infants are usually born with peculiarly malformed, low-set ears, often with skin-tags. They have markedly receding chins. The fingers are flexed and overlapping. The big toes are short and dorsiflexed. Intraventricular septal defects are the most common serious anomaly. These infants feed poorly, and have a poor cry and weak Moro reflex. They are mentally retarded, fail to thrive, and succumb early to cardiac decompensation and respiratory distress. The congenital malformations and findings which occur in more than 40% of the cases and are helpful in establishing the clinical impression of trisomy 17-18 are summarized in Table 2. The remaining anomalies were found less frequently, nearly half of them in singular instances.

Table 2

Most Common Findings

Low set ears, malformed	94%
Micrognathia	89%
Failure to thrive	82%
Flexed, overriding fingers	82%
Mental retardation	71%
Interventricular, septal defect	62%
Dorsiflexed big toes	58%
Spasticity	55%
Prominent occiput	42%
Poor sucking reflex	41%
Limited hip abduction	41%

Development: The physical retardation of these infants is shown by their small average birthweight and crown-to-heel length. The mean birth weight of 2,381gm is lower than Potter's value of 2,998.8gm, and the length of 44.2cm less than the average of 50.2cm for 10-month gestational age.

Survival: In contrast with abnormalities of the sex-chromosomes or Down's Syndrome, the chances for survival of children with trisomy 17-

*This tabulation will be furnished by Dr. Taubert upon request.

Table 3
MATERNAL AGE DISTRIBUTION

Age	Trisomy 17-18	General Population*	Mothers with Malformed Offspring**
14-19	1.9%	24.8%	21.9%
20-24	25.0%	29.1%	27.1%
25-29	9.6%	22.3%	20.3%
30-34	13.5%	14.1%	18.0%
35-39	21.1%	7.5%	9.3%
40-over	28.9%	2.2%	3.4%
	100.0%	100.0%	100.0%

* Based on 28,970 deliveries (1955-1963), University of Maryland.
** Based on 571 deliveries of malformed infants (1955-1963), University of Maryland.

18 are dismal. One may assume that only the more mildly affected cases result in full term gestation. Carr[31] considered two out of 12 abortuses with chromosomal abnormalities to be trisomic for No. 17-18.

At the time of reporting, only six of a total of 56 cases were alive. One of them had reached teenage, but this particular patient was only partially trisomic.[30]

The survival time was specified in 44 cases. It ranged from 36 minutes to 820 days. The mean survival time was 120 days. Only 47.8% of the infants lived longer than 100 days.

Cause of death: The cause of death was listed for 33 cases. Respiratory distress or pneumonia were most common, accounting for 54% of deaths. Other contributing factors were cardiac failure (42%), failure to thrive (9%), urinary tract infection (6%), and hepatitis (3%).

Causative factors: Since this syndrome had apparently not been recognized before Edwards[5] described it in 1960, extraneous or environmental causes similar to the thalidomide disaster have been suspected. The available data do not confirm this hypothesis.

Irradiation: Three mothers had been exposed to diagnostic doses of x-rays shortly after conception. Irradiation of the father could be established in two other cases.

Illness: One mother reportedly had a viral infection at the time of conception. Another one was hyperthyroid. No drugs were incriminated.

Heredity: Consanguinity was found once in a Mennonite family.[27] Siblings were found affected with trisomy 17-18 in three instances.[13,15,30]

There were nine cases of other malformations in close relatives. Chromosomal analyses of the parents of affected children proved to be normal in almost all cases. One carrier-state was uncovered. This particular mother had one chromosome 17-18 translocated onto one of the chromosomes 13-15.[2] The infant was partially trisomic with a translocation identical to the mother's.

Maternal age: Advanced maternal age was common in the 52 cases where this information had been given. The age at delivery ranged from 17 to 44 years. The average age was 32 years. Almost one-third of the mothers were older than 40, and 50% were older than 35. Table 3 shows the maternal age distribution of mothers of trisomic children in comparison with a series of women with malformed children and a general population.

Paternal age: Comparable data are not available in regard to paternal age. The range was from 22 to 54 years, with a mean age of 34. Paternal age seems to be a contributing factor in other trisomic states only in conjunction with translocations.

Duration of gestation: The difficulty of establishing the diagnosis of a post-mature gestation is too well known to be elaborated upon in this context. This problem is compounded in a series as presented here, which was derived from multiple sources. It seems nevertheless remarkable that 41.9% of the pregnancies were believed to have lasted longer than 40 weeks. In our clinic this would be considered a five-fold increase.[41] The number of infants born after 40 weeks of gestation increases with advancing age of the mother. Sixty per cent of the women aged 35 years and

more delivered after the expected date of confinement compared with 28.5% of younger women.

Delivery after term appears to be related to more severe affection. These children survived an average of 72 days, while those born at 40 weeks lived an average of 256 days.

Sex ratio: There were 37 girls and 18 boys and one whose sex was not specified. The resulting male: female ratio of 1:2.055 is more than twice the average ratio of 1:0.989 in our material. This is in full accord with previous reports.

This discrepancy is believed to be due to more severe affection of males. Such pregnancies supposedly terminate more often in abortions.[57] The relative lack of genetic material on the Y-chromosome, compared with the X-chromosome, is a possible factor.[37] Nevertheless, once development proceeds through the third trimester of pregnancy, both sexes seem equally severely afflicted. The survival times of male and female infants do not differ (males, 119 days; females, 121 days).

Race: All but three of the 56 infants were of caucasian extraction. Our patient was the second Negro child found to be trisomic for No. 17-18. Another infant was Chinese.[8, 27]

Laboratory data: Blood chemical and hematologic data were not pertinent and were not included in our tabulations. Specific roentgenologic findings were recently discussed by Moseley.[16]

Dermatoglyphics: Examination of the dermal ridge pattern is apparently more specific for establishing the diagnosis than any of the listed congenital defects. Only one-fifth of the cases were studied in this aspect. The most prevalent finding was the high number of digits with simple arches, absence of the distal flexion crease on most fingers, digital loops between III and IV, and wide, open fields on the soles.[10, 12, 52, 59, 60]

Cytologic examination: In a number of reports, as in ours, the diagnosis was suspected on clinical grounds. Since the morphologic findings lack specificity, the diagnosis will have to be verified by chromosomal analysis for the foreseeable future.

Cytologic data were related in 51 cases. In 41, a chromosome of group 16-18 (E) existed in triplicate. Two authors followed Edwards[5] and labelled the extra chromosome as No. 17.[4, 23] Several others remained undecided between No. 17 and 18.[9, 14, 16, 24, 25] The balance expressed preference for the autosome in position 18.

Double trisomies were observed thrice. The X-chromosome was triplicated in two instances, and No. 21 once in addition to trisomy 17-18. Five examples of partial trisomies or translocations were related. In two of them the triploid chromosome 17-18 was affixed to an accrocentric autosome of group 13-15.[2, 10] In another case the translocation affected chromosome No. 4.[7] The remaining cases were not detailed.

The possible gamut of abnormal karyotypes associated with this syndrome is complemented by one patient who had the expected defects but a normal number of autosomes.[3] In another case two stemlines of cells were found. One showed the trisomic chromosome; the other one was normal.[15]

Not included in the tables was a child reported by Ferguson et al[34] with similar defects and 47 chromosomes. The extra chromosome resembled No. 22 but was believed to be an incomplete chromosome No. 18.

Incidence: Since the first report of this syndrome, a large number of cases have been diagnosed. Several authors, especially Uchida and Smith, saw surprisingly many examples of this entity.[20, 21, 26, 27, 40, 57]

Unless a definite cause for this sudden surge can be found, it is safer to assume that such cases were formerly reported under various eponyms. There are striking similarities to the Pierre-Robin syndrome, which is characterized by micrognathia and glossoptosis.[55] One of Koenig's cases of this syndrome was subsequently found to be trisomic for chromosome 17-18.[14] We saw such a case in 1957, which in retrospect appears compatible with a trisomy.

Pfeiffer et al described a case of trisomy 17-18 appearing clinically as arthrogryposis multiplex congenita.[17] Gaylor and Fried, however, could not confirm this finding in their case material.[39]

Frequent features of trisomy 17-18, such as low-set ears, micrognathia, and hypertelorism, are considered typical findings in Potter's syndrome of renal agenesis.

It is difficult to quote even the approximate frequency of this aneuploidy. Smith found three cases in 10,345 consecutive deliveries. This represents an approximate incidence of 1:3500 deliveries.

We reviewed 28,970 deliveries over the past eight years for combinations of congenital malformations suggestive of trisomy 17-18. There were 571 malformed infants (1.9%), none of which presented with suggestive lesions.

Prenatal factors: Sparse data are available concerning gestational history. The suggestion has been made that such pregnancies follow sterility. This does not seem to be factual. The average number of pregnancies per woman was 3.65; the number of term deliveries, 3.15. Only three of these women were nulliparous, and two of these were young. Nine had had many pregnancies.

Decreased intrauterine activity during the last weeks before delivery was noted in the few reports where these parameters had been considered. In such event polyhydramnios, single umbilical arteries, and rather small placentae were commonly found.[6, 8, 12, 21, 22, 27, 28]

Comment

Failure of the homologous chromosomes to separate during the first meiotic division will result in one gamete with 24 chromosomes and one with 22. The former would produce at fertilization a zygote with 47 chromosomes. In the latter case a non-viable zygote with 43 autosomes would result. Non-disjunction can also occur at the second maturation division. If there is only little crossing-over at this stage, the resulting chromosomes would bear almost identical genetic information. Relatively mild cases of trisomic states could thus be explained.[14]

The occurrence of mosaic autosomal trisomies suggests the possibility that postzygotic mitotic divisions might be non-disjunctional. Mosaics are difficult to exclude even if more than one tissue has been examined. The relation between the two stemlines might be altered according to the ability of the aneuploid cells to reproduce.[57]

The nomenclature of this and other chromosomal anomalies has been confused. Edwards[33] suggested recently to denote the various syndromes according to Patau's classification rather than the Denver system, with a suffix indicating the sequence of their respective recognition. Trisomy 17-18 would thus become Trisomy E_1. This system is plausible but does not allow for immediate recognition of the chromosome implicated.

The presented material confirms that advanced maternal age is the only obvious etiologic factor.[50] The same has been observed in other congenital anomalies. The incidence of women past their 35th year in our material approximates the percentages reported for Down's syndrome (58%) and Trisomy D_1 (40%) and is considerably higher than the average (9.9% at University of Maryland, 11.8% University of Wisconsin).[57]

Iffy suggested that postmidcycle ovulation is responsible for most fetal monstrosities. Delayed ovulation produced malformed progeny and chromosomal abnormalities in amphibians. Advanced age per se was no factor.[62] It has been postulated that the ova of older women are deficient in their cytoplasm. This will express itself during the meiotic and first postzygotic divisions, when the ovum and zygote respectively still depend environmentally upon the cytoplasm derived from the gamete.[49, 53]

The malformations are mostly due to arrested development between the eighth and twelfth weeks of fetal life.

The anlage for the external ear is below the region of the mandibula. Defects of these are always associated, usually in conjunction with a small oral cavity.[16] This defect of the first branchial arch and the interventricular septal defect appear to be the most specific combination of useful diagnostic criteria for trisomy 17-18. However, no anomaly so far has been shown to be specific for a trisomic state.[57] Every anomaly presents at least one gene locus in the normal development of the afflicted organ, so trisomy might be a means of establishing autosomal linkage groups in man.[50] For this reason complete reporting of the defects observed is highly desirable.

The severity of this syndrome does not make it amenable to therapy.

Confirmation of the diagnosis by chromosomal studies not only is of academic interest but is important for counseling parents concerning the prognosis of the particular child and the possibilities of it occurring again in future offspring.

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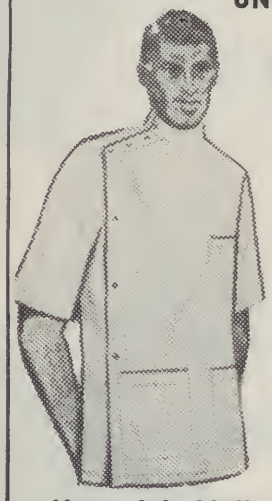
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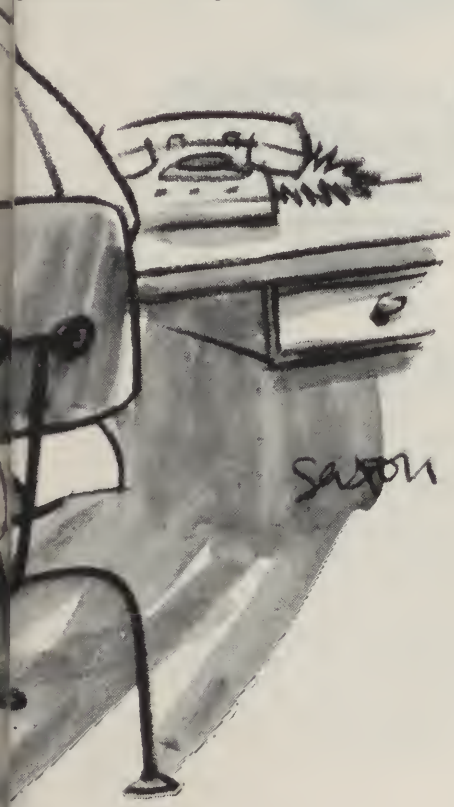
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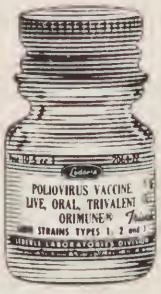


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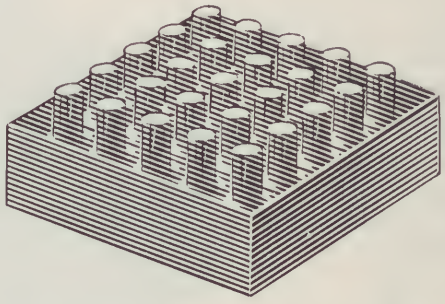


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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Psychological factors play a prominent role in patients' reactions to even the most potent chemotherapeutic agents. Psychological factors include:

- **The patient's attitudes, hopes, expectations, and fears**
- **The patient's conception of the nature of his illness, and hence his conception of the appropriate remedies**
- **The patient's past experiences with drugs and with doctors**
- **The symbolic meaning of the drug to the patient**
- **The interaction between the drug's pharmacologic effect and the personality structure and defensive system of the patient**
- **Psychological factors in the doctor which influence the context in which he prescribes drugs and the manner in which he does so**
- **The interpersonal relationship between patient and doctor in which communications occur simultaneously on many levels.**

The degree of success to be attained in chemotherapy will be influenced by the physician's attention to these factors.

PSYCHOLOGICAL FACTORS IN DRUG ADMINISTRATION

GERALD D. KLEE, MD
Associate Professor of Psychiatry
The University of Maryland School of Medicine

From ancient times the practice of medicine has been associated with the administration of drugs. We now recognize that throughout most of medical history the majority of drugs in use were pharmacologically useless or even harmful; hence whatever success physicians achieved can be ascribed largely to nonpharmacologic factors. In the present era, pharmacology has become a highly sophisticated science, and chemotherapy continues to make great strides. It is now over a decade since psychopharmacology has appeared as a unique branch of chemotherapy. This new arrival has already established a firm and growing role in the treatment of minor and major emotional disorders.

Despite the undisputed successes of pharmacology, most experienced physicians would agree that the doctor himself is the most potent therapeutic agent and that the doctor-patient relationship has a powerful influence, for good or ill, on the effectiveness of any type of chemotherapy. I shall discuss some of the most significant psychological factors which are involved in chemotherapy. Although I will refer chiefly to the use of psychotropic medications, most of the principles apply to all forms of chemotherapy.

When a patient seeks the help of a physician, he hopes and expects relief of his suffering. The patient usually has a past history with his symptoms and quite possibly with other forms of treatment, either with the present doctor or with others. He also may have his own theories about what is really wrong with him. Quite often he has fairly definite ideas about what he wants the doctor to do. Everyone has seen the kind of patient who simply won't be happy until he gets a shot of penicillin for his cold and will not rest until he finds the doctor who will give it to him.

Patients with anxiety, depression, or other symptoms related to emotional disturbances may be determined that the doctor shall find organic causes for their symptoms and that he shall pre-

Adapted from a presentation on this subject in the Postgraduate Course in Psychiatry for the American College of Physicians, June, 1964.

scribe a somatic form of treatment, such as chemotherapy, for them. Moreover the patient may present his symptoms in a manner designed to elicit the desired response. The physician may be faced with the dilemma of either losing the patient or prescribing a useless or harmful form of treatment which will only reinforce the patient's erroneous beliefs about his illness. In these cases, however difficult it may be, it is usually desirable to make the effort to relieve the patient of some of his misunderstanding about the nature of his problems, whether or not chemotherapy later proves to be indicated.

Many patients have difficulty in thinking of illness in other than concrete terms and may come for treatment imbued with ideas of the magic of modern medicine. The patient may expect, or at least hope, that the doctor will be able to provide him with some miraculous cure which will relieve him of all his troubles with little or no effort on his part.

The prototype for this type of relationship is the patient suffering from an acute abdomen who sees a surgeon. The doctor makes the diagnosis; the patient is put to sleep with a general anesthetic, and with practically no participation on his part other than passive cooperation, he is relieved of his inflamed appendix.

The emotionally disturbed patient may be disappointed and angry to discover that the doctor has no miracles for him, and the doctor himself runs the risk of feeling inadequate in being unable to satisfy the patient's unrealistic expectations. Many therapeutic errors are the result of the physician's efforts to avoid recognition of his own feelings of impotence.

Administration of a drug is a concrete act which may have a wide variety of meanings for the patient, and these meanings may have profound influence on his reactions to the drug. For some patients, when the doctor gives drugs it means that the doctor really cares and really wants to help. It may mean to the patient that at last he has found someone who will, in a sense, give him the love that he has been unable to receive elsewhere. A young woman who was in psychotherapy for a mixed psychoneurosis and many interpersonal problems made numerous requests over a period of time that she be given medication. In the course of her treatment she ultimately developed symptoms for which a tranquilizer was indicated. A new experimental drug in which her psychiatrist was interested at the time was administered. On her next visit she reported a dream which she had had on the first night after receiving the medication. In her dream, her psychiatrist was holding a big party in his office. He had huge bags of candy and cookies and invited her to take all she could eat. Needless to say, she had immediate relief from many of her symptoms, including a rather severe anorexia. This same drug was later removed from production by the pharmaceutical house which prepared it because it was found to be generally ineffective.

For other patients, when the doctor gives drugs for emotional problems it may signify that he doesn't care about what's really bothering the patient and just wants to brush him off. Such a feeling may be justified at times, especially when the physician spends little time interviewing the patient.

With all centrally active drugs one sometimes encounters paradoxical reactions. Many of these reactions can be understood on a psychological rather than a pharmacologic basis. To do so it is necessary to consider the interaction between the drug's effects and the personality structure and defensive system of the patient. For example, some patients suffer from severe feelings of passivity, helplessness, and inadequacy which they may defend against by being physically or mentally hyperactive. Sometimes administration of a tranquilizer to this type of patient, by making him feel physically and mentally sluggish, will interfere with his major defensive patterns. He may react to this with increased anxiety and agitation. This sequence of events is especially common in adolescents but may occur in any age group.

A severely depressed 47-year-old women had a life-long reaction pattern, when faced with any type of adversity, of imposing greater and greater demands upon herself. During the year before her treatment, her life situation had become increasingly desperate. She responded to this by doubling and redoubling her physical and mental efforts. This, in turn, led to exhaustion and almost complete ineffectiveness. She was placed on Amitriptyline HCl (Elavil), an antidepressant, which has mild sedative effects. She soon complained that the drug made her feel relaxed and lazy, and this wouldn't do, because she had so much work to do; although in reality she was now accomplishing more with less effort. She also complained of the mild feeling of well-being

which the drug gave her. It appeared as though this patient could not immediately accept the mildly euphoric effects of the drug because of an intense (and unjustified) feeling of sinfulness, with a consequent need to suffer.

Patients will also complain about the side effects of drugs, even when taking placebos. It is well to remember that often such complaints, rather than being merely a concern with subjective discomfort, are ways of covertly communicating dissatisfaction with the doctor or with various aspects of the treatment. In other cases, the patient believes he is getting a placebo unless he notices some side effects; in fact, some drugs, such as nicotinic acid, with limited pharmacologic action but distinct side effects, are used to treat a wide variety of disorders. This is only one of many well known drugs which produce little other than side effects.

Everyone is familiar with the hostile-dependent patient who will call the doctor in the middle of the night for minor complaints and make numerous demands upon him but is never satisfied. One has to be especially careful when administering psychotropic drugs to such patients, since the same game can be played with drugs. Some physicians have the unfortunate experience of going through the whole pharmacopeia with a patient of this sort before finally realizing what is going on. A time-consuming, but necessary, verbal clarification of what is going on in the relationship may permit successful management of such cases.

Let's now turn to the other side of the equation: the doctor, and the relationship between doctor and patient. Because of his own needs and his personality structure, the doctor may unwittingly foster many of the attitudes in patients which we have just described. In his conception of himself as a physician, he may devalue the psychological components in the doctor-patient relationship and may feel obliged to employ organic forms of treatment even when they are inappropriate. He may have a need for his patients to worship him or to depend upon him and may unconsciously employ psychotropic drugs to further this end. The most common risk is that the doctor will be too busy to listen to the patient and may feel inadequate to deal with the patient's psychological problems. It is certainly much quicker and easier to administer drugs at such times, but under these conditions, the psychotropic drugs are least likely to be effective.

The doctor's own feelings about the effectiveness of the drug he is prescribing and the manner in which he presents it to the patient have been shown to markedly influence the therapeutic response,[1] hence the phenomenon of new drugs sometimes showing amazing effectiveness at first, followed by much more modest results after the initial enthusiasm wanes. This has led to the rule: "When a new drug comes out, use it as often as possible while it still works." It is probably true that even an effective drug attains its full effectiveness only when administered under optimum psychological conditions, which include an attitude of interest and hopefulness in the doctor.

I have only touched upon the subject of placebos. This much belabored topic will not be discussed, except for a statement by Lasagna,[2] a pharmacologist, which bears repeating:

> Certain primitive maneuvers are necessary to insure the success of this pharmaceutical charade. First, the patient must be kept unaware of the deceit. A good start is usually made with the writing of the prescription. The well known illegibility of these scripts frequently makes it impossible for a curious patient even to guess at the nature of the medicament. If the handwriting is legible, it is still likely to be in Latin. To guard against the possibility that the patient will ask the pharmacist about the contents of the prescription, physicians are well advised to steer clear of milk, sugar, or other well-known ingredients. There are available various vile-tasting and vividly colored tinctures which not only are impressive in physical properties but bear names calculated to inspire confidence in the erudition of the prescriber. Names such as ammoniated tincture of valerian can safely be revealed to the patient without upsetting the psychological applecart. Some authorities consider the color of the preparation very important. Colorless capsules are presumed to be unimpressive. One writer advises yellow, orange, or brown; another prefers pink, blue, or a mottled design. Similarly, tasteless placebos are considered inferior to a bitter or highly flavored one. It is believed that an extraordinarily large pill impresses by its size, an exceptionally small one by its "potency." An injection is thought to be more effective than something taken by mouth; presumably the presence of the nurse or physician necessary for the injection is an important component of the psychological effect.

The Psychiatric Institute
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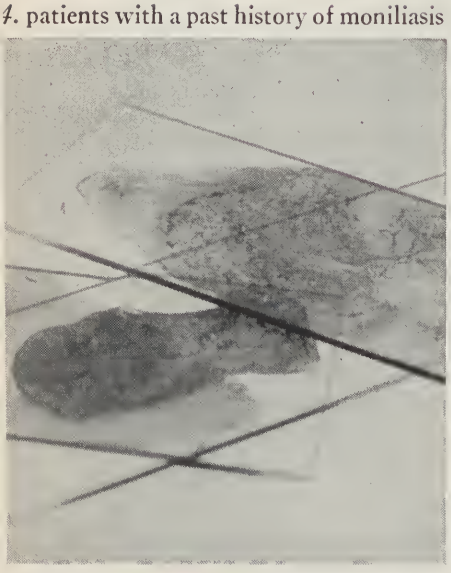
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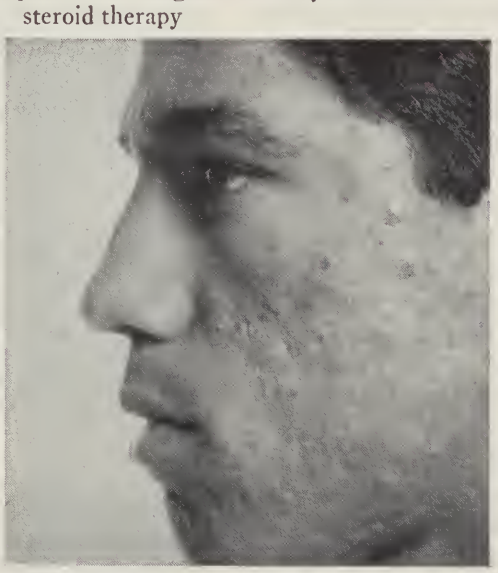
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PERSONALITY DIFFERENTIATION OF PATIENTS WITH CORONARY ARTERY DISEASE

A brief objective-type personality scale was administered to 29 patients recovering from myocardial infarction at the Albert Einstein Medical Center. The instrument was also administered to 119 non-coronary (primarily postsurgical) patients. Equating on important variables led to close matching of 24 pairs of coronary—non-coronary patients. The number of personality test items showing statistically significant differences could readily be accounted for by chance variation. This finding raises questions concerning the validity of claims that such traits are precursors of coronary artery disease.

N. RICHARD ALTLAND, PhD
ELLIS WEITZMAN, PhD

As part of a much larger investigation instituted by Krasnoff and Oscherwitz,[1] at the Albert Einstein Medical Center in Philadelphia, an especially prepared 90-item form of the Guilford-Zimmerman Temperament Survey, measuring factors G, R, and E, was administered to 29 myocardial infarction patients and 119 non-coronary disease patients, predominately postsurgical convalescents. The questionnaire assessed the following traits commonly associated with enhancement of coronary disease onset.[2]

General Activity (G): A high G score represents strong drive, energy, and activity. On the other hand, a low G score indicates slowness or inactivity. The G factor is a kind of catalyzer, for its coupling with other factors has varying interpretations.

Restraint (R): A high R score represents restraint and seriousness, and a low R score indicates a happy-go-lucky, carefree, impulsive individual. A high R score coupled with a very high G score may indicate internal conflict and consequent danger to mental health.

Emotional Stability (E): A high E score indicates optimism and cheerfulness, whereas a low E score represents depression and emotional instability. A high E score coupled with a low G score may indicate a sluggish, phlegmatic, or lazy individual. A low E score is a sign of neurotic tendency.

The acute myocardial infarction patients were matched with the non-cardiac patients on the following eight parameters: age, sex, nativity, educational attainment, source of income, occupation, social class, and smoking habits. This equating resulted in 24 matched pairs of subjects (see Table). Each of the three personality factors, each of the

MATCHED-PAIR FREQUENCY DISTRIBUTIONS FOR CONTROL VARIABLES

Variable	Class Intervals	Frequency *MI Group	Frequency **Comp Group
Age	28-37	1	2
	38-47	7	4
	48-57	10	13
	58-64	6	5
Sex	male	20	20
	female	4	4
Nativity	Pennsylvania	19	19
	New York	3	3
	Maryland	1	1
	U.S.S.R.	1	1
Occupational Status	Warner Level 1		1
	" " 2	4	4
	" " 3	5	4
	" " 4	9	14
	" " 5	3	1
	" " 6	3	
	" " 7		
Source of Income	Warner Level 1		
	" " 2		
	" " 3	6	7
	" " 4	11	15
	" " 5	7	2
	" " 6		
	" " 7		
Educational Attainment	Warner Level 1		2
	" " 2	5	2
	" " 3	3	2
	" " 4	4	5
	" " 5	6	5
	" " 6	4	6
	" " 7	2	2
Social Class	Warner Level 1		
	" " 2	4	5
	" " 3	11	12
	" " 4	9	7
	" " 5		
Cigarette Consumption History	Smokers	22	22
	Non-smokers	2	2

* Myocardial infarction group
** Comparison group

90 test questions, plus failure-to-answer responses comprised the 96 independent variables of the study. Statistically significant relationships, at the 5% level of confidence, were found on the following two items: "You take life very seriously" and "When you get angry, if you let yourself go you feel better."

Although these two items may provide important clues for further investigation, none of the factors showed significant score differences between the groups, nor was there any difference in failure-to-answer scores. This study does not, therefore, reveal any measurable difference in personality traits, despite the widely-held belief to the contrary. It should be remembered, however, that this investigation dealt with post-infarction rather than precursors of coronary artery disease. On the other hand, every attempt was made, *ex post facto*, to find significant precursors among the massive data accumulated in the survey of patient background. The scope of background data is evidenced by the fact that more than 800 types of information were recorded.[1]

It is safe to assume that the two significant test questions may readily be attributed to chance when the total number of test items used is taken into account. This same conclusion may well be applied to the more flattering findings of other investigators using objective-type personality tests, especially since replication of findings is not evidenced. In view of the fact that vast numbers[3] of people are victims of coronary artery disease (more than 39% of all deaths being due to coronary artery disease) and that cardiologists' offices are filled with virtually all types of people, it is hardly likely that all of them possess a common set of emotional traits or fall into a single personality type or profile.

American University
Washington DC 20016

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Trends of the Mental Hospital Population of the United States With Special Emphasis on Maryland

KURT GORWITZ
Director of Statistics
State of Maryland Department of Mental Hygiene

For many years the patient population of state and county operated mental hospitals in Maryland and throughout the United States rose at a steady pace. After the Second World War, this increase was particularly pronounced and persisted until the middle of the 1950's.

Construction of most hospital facilities had been at a minimum during the depression years of the 1930's and came to a halt during the war. After 1945 construction usually did not keep pace with the rising patient population, resulting in almost unbelievable overcrowding and human degradation.

In Maryland, a series of newspaper articles in the Baltimore *Sun* in 1949 focused on "Maryland's Shame." A cry of surprise, shock, and indignation resounded throughout the state. Demands for action were heard everywhere. The voices were loud enough and clear enough to penetrate the Governor's ears. A similar story was told in many other states. In Maryland, as elsewhere, the answer to these dismal and disconcerting facts was to increase funds for the construction and staffing of facilities and for improved patient care and treatment. The increasing patient figures indicated an ever continuing need for more and bigger psychiatric hospitals.

A change began in 1950, the importance of which was at first not readily realized. Although the population of these facilities continued to go up, the ratio of patients to total population of the United States began to decrease. That is, the average patient population rate began to go down, slowly at first, but persistently. Beginning around 1955 the upward hospital population movement reversed in Maryland and in most other states, and a continuing decrease appeared. Every year since that time, the reported average patient population of state and county psychiatric hospitals has gone down. From a high of around 550,000 in 1955 this population has now declined 10% to approximately 490,000. In 1955, there were 342 patients in these hospitals for every 100,000 residents. Now there are 254, a decline of 25%. In Maryland, the average population size of state hospitals has dropped 17%, from a high of 9,424 in 1955 to 8,076 in 1965. This has occurred during a period when Maryland's total population increased 25%.

At the same time, the population composition of these hospitals has changed substantially, due to the large increase in admissions and releases. As shown in the table, admissions nearly doubled in the last 10 years while releases are now more than twice as large as they were in 1955. Proportionally, releases have consistently risen faster than admissions; and this has been the major factor in the decline of the patient population. At the same time, the percentage of all psychiatric hospital beds occupied by chronic patients is slowly decreasing, and the average age of hospital patients is now going down.

Based on a talk presented at the mental health seminar of the Johns Hopkins School of Hygiene and Public Health.

Patient Movement Statistics
State And County Psychiatric Hospitals
Fiscal Years 1954-1964

Fiscal Year	Average Expenditure Per Patient	Average Resident Population		Admissions		Net Releases	
		#	Rate*	#	Rate*	#	Rate**
1954	$1,036	547,393	344.1	167,185	105.1	111,698	204.1
1955	1,108	554,592	341.6	173,864	107.1	115,930	209.0
1956	1,195	555,103	335.7	185,597	112.3	133,208	240.0
1957	1,332	548,626	325.8	194,497	115.5	145,116	264.5
1958	1,475	546,337	318.7	209,503	122.2	161,972	296.5
1959	1,567	542,135	310.8	222,791	127.7	176,411	325.4
1960	1,702	538,725	303.4	234,846	132.2	191,415	355.3
1961	1,834	531,791	293.5	253,005	139.6	215,600	405.1
1962	1,983	521,159	283.7	270,767	147.4	230,899	443.4
1963	2,120	511,708	274.3	285,244	152.9	247,228	483.1
1964	2,280	496,661	262.3	302,946	160.0	271,506	545.6

* Per 100,000 Total Population
** Per 1,000 Average Patient Population

A mistake which is often made is to look only at the whole without recognizing that it consists of various individual pieces which may have radically different compositions. For example, although the patient population is now 10% lower than it was in 1955, nine states have shown an increase in their hospital population during this period. Similarly, the patient population under age 25 expanded, with an average annual rise of 6.4% in the age group between 10 and 14. This later increase is largely the result of a long overdue recognition by many states of the special problems and needs of these young people. In Maryland, for example, we now have the Esther Loring Richards and Finesinger units of the Department's Institute for Children; and other facilities are contemplated.

Many other states have exceeded Maryland's decline in patient population with reductions of 30, 40, and even 50%. For the nation as a whole, substantial declines are reported in many age and diagnostic categories. What does all this mean? Have we experienced a genuine decline in our hospital populations, or has this apparent decrease simply meant that we have transferred our problems elsewhere, to such facilities as private and general hospitals, nursing homes, local welfare departments, outpatient psychiatric facilities, and others? How many released patients function adequately as family and community members? In how many cases have we provided an agent responsible for the growth and development of mental disturbances in others? In Maryland we hope to be able to study some of these factors through our Psychiatric Case Register. Many other studies are needed.

Much of the available data fortifies the belief that we have experienced a genuine decrease in the psychiatric patient population, but others are dubious, since not all the evidence is available. For example, little is known about the patient population treated in private psychiatric hospitals, in psychiatric units of general hospitals, and in the facilities of the Veterans Administration. Has the decline in patients in state facilities been balanced by an increase in these hospitals?

Nationally, data are available on only a portion of these hospitals. These statistics indicate that there are a minimum of 16,000 beds for psychiatric patients in private hospitals, 9,000 in general hospitals, and 55,000 in VA hospitals. Annually, they treat approximately 90,000, 225,000, and 110,000 patients, respectively. They thus provide 15% of all psychiatric beds and care for one-third of all hospitalized patients. However, since national figures are not available for all facilities, the changing trend in these hospitals cannot be readily determined.

In Maryland (where reports are received from all facilities), 25% of all psychiatric beds are in non-state operated hospitals (approximately half of these are at the VA Perry Point Hospital). Generally, private and VA hospitals have experienced a trend similar to state hospitals, greater patient turnover and a declining population.

It is generally accepted that psychiatric admissions to general hospitals are increasing rapidly with a rising number of facilities offering these services. Since many of these facilities handle only short-term treatment cases, their patient turnover is much greater and they account for nearly 40% of all admissions and terminations. While a large majority of patients in private and general hospitals are female, the reverse is true in state operated facilities. The preponderance of males in the state facilities is primarily due to the fact that 40% of admissions to state hospitals have a primary diagnosis of alcoholism. Nine out of ten of these patients are males.

My personal belief is that there has been a genuine decrease in state psychiatric hospital populations, although this decline is probably smaller than indicated by the usually available figures. The following facts from Maryland fortify this:

1. Admissions to state hospitals are increasing at an accelerating pace. Releases are rising even faster.
2. The psychiatric patient population in other hospitals has not increased in recent years.
3. The number of patients on foster care has not changed. Nursing home placements have been on an individual basis and are few in number.
4. Only a small number of former patients have become chronic welfare cases.
5. New drugs and available supportive services have enabled many long term patients to return to the community as functioning members.

What of the future? Some years ago President Kennedy, in his special message on mental illness and mental retardation, said, "If we launch a broad new mental health program now, it will be possible within a decade or two to reduce the number of patients now under custodial care by 50% or more."

All indications are that this numeric goal will not be attained unless there is a major change in presently existing programs. At the present time, the average size of the U. S. patient population is declining between 1 and 2% annually. However, much of this decrease has been concentrated in a few states where in many cases substantial transfers of chronic patients to nursing type facilities have taken place.

In most states chronic patients continue to occupy between 50 and 75% of all hospital beds. Treatment services are generally meager, and patients remain hospitalized until their death. In Maryland state hospitals, 54% of the patient population has been hospitalized continually for five years or more. Clearly, then, President Kennedy's hope can only be reached through a twofold program which would 1) minimize the number of new cases requiring long term hospitalization, and 2) reduce the size of our current chronic population. The former can be reached if we could reduce admissions by developing comprehensive community centers and other alternatives to hospitalization while increasing releases by providing more community supportive programs. The second objective can be reached by expanding current treatment programs, developing new treatment concepts, and increasing foster care, nursing home, and other related programs.

The attainment of these numeric objectives should never be our sole concern. It should not even be our prime concern. I do feel that we should tone down on our numbers games and reaffirm our basic aims. Clearly, we need alternatives to hospitalization. But these will be senseless unless they can be of greater and more lasting help to the patient and his family than the hospital would be. Clearly, we need to reduce the length of hospitalization and to maximize releases. But shouldn't our objective be to speed the return of the individual to an environment where he can function in a more positive manner and be more accepted by his peers? Clearly, we need more nursing homes and foster care facilities. But do we merely need more, or do we want alternatives which will provide equal or better services to the chronically ill person?

I feel that our objectives are clear and the goals are reasonable. Reduce the hospital populations? Yes; but let us seek to attain this desirable goal only through a closely coordinated program involving all potential resources and offering the best available services to our mentally ill.

2100 Guilford Avenue
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RESOLUTIONS . . . .

All resolutions to be presented to the House of Delegates at its meeting on **Friday, September 9, 1966,** must be in the Faculty Office, 1211 Cathedral St., Baltimore, Maryland 21201, no later than Friday, **July 15, 1966.**

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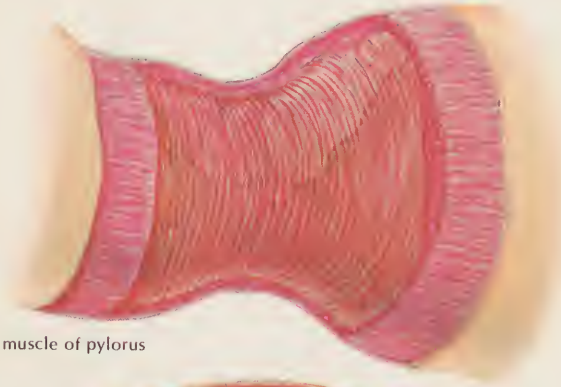
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smooth muscle of colon



smooth muscle of pylorus



smooth muscle of uterus



smooth muscle of urinary bladder

POWER OF THE STATE TO IMPOSE MEDICAL TREATMENT

L. WHITING FARINHOLT, JR.
Professor of Law,
University of Maryland Law School

WILLIAM J. O'DONNELL
State's Attorney, Baltimore City

Moderated by Howard F. Kinnamon, MD

DR. KINNAMON: Our topic tonight might sound confusing from its title, "Power of the State to Impose Medical Care." This is not the program of socialized medicine that is so frequently discussed but that of the State's authority to authorize medical care to a child whose parents for one reason or another refuse this care; or to a wife who needs surgery and transfusion but refuses on religious grounds. There is also the problem of innoculations, vaccinations, and other immunizations required by law.

When a child needs an operation; when a mother needs a transfusion and probably surgery, and permission is refused, what do we as doctors do? To whom do we turn? If permission is granted by the courts and the outcome of the surgery is not what was hoped for, what is the medical responsibility?

Our panel is composed of two able men. One is a professor at the University of Maryland Law School and a member of Medicolegal Committee for many years, Mr. Whiting Farinholt. The second participant is Mr. William O'Donnell, states attorney of Baltimore City, a very astute, able young man. These young men are going to tell us the legal responsibilities to the child and to the adult.

MR. FARINHOLT: I am glad to be here this evening and to have been asked to participate as a member of this panel tonight. It is a real honor as well as a responsibility.

A number of times in the past I have had the opportunity to talk to a mixed audience, such as this, composed of members of our two disciplines, medicine and law. I find it always a most difficult task on these occasions, since one's remarks are often likely to be found either overly elementary or, on the other hand, incomprehensible, depending upon the particular profession of the individual listener.

Tonight my comments will be addressed, in the main, to the members of the medical fraternity. My object is to present for their interests, and possibly for their enlightenment, some of the legal problems, concepts, and formulas relevant to our subject. In no sense will this be the sort of presentation one would prepare as an argument for a court, nor even a discussion before a law club; rather, it is an attempt to provide a quasi-legal climate for members of the medical profession, so that, at the conclusion of my remarks we can possibly indulge in a sensible discussion as to some of the points therein.

I have a firm conviction that whenever members of separate disciplines get together and more or less calmly discuss matters and issues common to both of them, something of benefit to each discipline results. This, it seems to me, is particularly true in our two professions, law and medicine. Whether we individually like it or not, circumstances require us to work together, and cooperation is made more palatable, even pleasant and fruitful, when each knows something of the other's problems, attitude, and approaches.

In discussing the manner of presenting our subject tonight, Mr. O'Donnell and I decided that we would divide the basic question into two areas and that I would deal primarily with that area in which children are involved; that is to say, those

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situations where a parent neglects to provide medical care for his child, or, more importantly, where the parent refuses to permit the child to undergo medical treatment which is necessary for the child's health or even for his life.

First, a few basic and fundamental concepts should be stated. These are self-evident and elementary; but as a foundation for the discussion, they at least need to be mentioned. An individual who is neither incompetent nor under some sort of legal disability may reject medical care for himself. He may not be forced to submit to medication or surgery. The privilege or right to refuse treatment is practically absolute, even in the face of inevitable death. There have been a number of cases in which a physician or hospital has been held civilly liable in tort for battery when the surgeon has proceeded without the consent of the patient or has exceeded the consent granted.

There is a story of a famous surgeon associated with one of our great eastern hospitals. While conducting a brain operation involving the removal of a tumor, there were a number of other surgeons around him observing his extreme skill and dexterity. When he completed this difficult but successful operation, his fellow surgeons broke into applause. Apparently this overwhelmed the good doctor. The acclaim went to his head, and he, by way of an encore, performed a circumcision.

His additional conduct, of course, is beyond the consent granted and would amount to a tort—a battery in the language of the law. Some measure of consent must be obtained from the patient or from one on his behalf; otherwise an action for damages will lie.

This is not news, of course, to you, I am sure. However, the question of consent is itself a truly sticky problem. It is not my purpose to investigate with you this area at the moment. Numerous perplexing problems may arise, among them, who may consent, under what circumstances may consent be implied, what are the essential elements of consent, and so forth. My colleague, Mr. O'Donnell, will deal with this area.

An excellent article, entitled "Consent to Operative Procedures," was published in the *Maryland Law Review* in 1961 and was reprinted with slight modification in your own *Maryland State Medical Journal,* in the June, 1963, issue. Its author, Robert Powell, when he started this work, was a member of my Medicolegal Seminar, and I am indeed proud of the beginning he made there and of the final effort as it has been published.

As the primary basic proposition, then, a physician or any other person who treats an individual without his permission and against his will is answerable in civil damages.

A second fundamental concept, relevant here, is the right of parents or those who stand in *loco parentis,* such as a guardian, to the custody and control of a minor child.

A third basic concept is that the sovereign, the State, has inherent power under the police power to provide within reasonable limits for the health, safety, and general welfare of society. This latter concept, when applied to the sovereign's power of guardianship over a person with a disability, as, for example, a minor child, is known as *parens patriae.*

These three basic propositions: 1) the need for consent or permission before medical treatment is administered; 2) the right of the parent to control the child; and 3) the power of the State to act as guardian of one under disability—define the area of our discussion. It is the resolution of these often conflicting principles that is our aim tonight, as it has been the aim of the court when confronted with a situation in which parents deny their child medically indicated professional treatment.

There developed in this country and in the State of Maryland two separate approaches for handling the problem of medical care for children over the parental objection: first, statutes invoking criminal sanctions for neglectful parents; and, second, those empowering juvenile courts to remove the child from the custody of the neglectful parent.

Obviously, the first or criminal approach is effective only as an *ex post facto* sanction to punish the parents for the failure to perform a legal duty; that is, to give adequate care to the child. Unfortunately, it does little to benefit the child, and none if the child has died because of parental neglect.

Even in the absence of statute, the common law uniformly places upon the parent an obligation to provide for his offspring in sickness or ill health. This view has been codified into the Maryland Code, Article 72A, Section 1: The mother and father are jointly and severally charged with "support, care, nurture, welfare, and education of their minor children."

"Support, care, nurture, welfare, and education." It may be noted that the statute does not mention medical care in specific terms. However, in a recent case, Craig vs State, (220 Md 590, 1959) the parents were criminally indicted and prosecuted for involuntary manslaughter for failing to provide medication and medical care for their ill child. Though the case did not result in conviction, for another reason, it would seem to be adequate authority to support the contention that failure of a parent to provide medical care for his offspring is a violation of the criminal law.

Under the second approach, that is, the removal of the child from parental custody, our local statute setting up the juvenile court system under which a child may be withdrawn from the parents' control and custody is more explicit regarding medical care. "Medical care" is specifically set forth in Article 26 Section 51 et seq.

Thus by statute and case law, we clearly recognize parents as the natural guardians of their minor children and that they are entitled to their care and custody. Yet this right is a qualified one which may be forfeited either if the parents become unfit to retain custody or, under exceptional circumstances, if continued custody of the parents would be detrimental to the best interests of the child.

The cases Mr. O'Donnell will cite and describe, I am sure, will illustrate that there are parents, unfortunately, whose claim to parenthood and the rights thereunder are little more than biologic.

Thus Article 26, section 51, gives the circuit court of each county jurisdiction in juvenile causes. Section 52, subsection 4 of that same article defines a neglected child as a child "whose parents, guardian, or custodian neglects, refuses, when able to do so, to provide necessary medical, surgical, institutional, or hospital care for such child."

Section 53 gives the judge of the juvenile court original exclusive jurisdiction, both over the child who is "dependent, delinquent, neglected, or feebleminded," and over the parents who contributed to or caused the child to be brought within the jurisdiction of the court.

Under this section of the Code, permitting the State to remove the child from parental custody and to impose medical care upon him over the objection of the parent, the procedure is basically simple. A petition is filed in court alleging that a specific child is being neglected and stating the basis for such allegation. On the basis of this petition, the court decides whether or not it has jurisdiction, and, deciding that it does, conducts a hearing to determine the question of neglect. If the court determines the child to be neglected, an order may be issued committing the child to a guardian, who is authorized then to consent to the medical care which is deemed necessary.

In reaching a decision, the court has at its disposal social and medical data reports compiled by the Department of Public Welfare and has access to other medical opinion. It is usual in such cases that a conference be held with the dissenting parents in an effort to persuade them of the importance of the child's obtaining medical attention. Only when such efforts fail does the court overrule the parents' objections and enter an order committing the child.

When failure to provide medical care is the only basis for finding neglect, the commitment is usually temporary; after the needed medical treatment has been provided, custody of the child usually reverts to the parents without further court action.

Though the "juvenile causes" section of the Code, Article 26, which provides for the removal of the child from the parent's custody, has apparently been invoked rather frequently, there is little case law interpreting the statute. Newspaper accounts and personal interviews with juvenile court officials, pediatricians, and others indicate that several times petitions for change of custody of children on grounds of parental failure to provide necessary medical care have been filed and acted upon.

Clearly, then, we have the procedure for removing the child from the parent's custody. But what are the criteria for effecting the removal? Specifically, under what circumstances will a child whose parents refuse him medical care be characterized as neglected so that the situation falls within the statute? What is necessary medical care?

These are questions which, in each case, must be determined on the facts of that case. There are a number of factors which have been given weight by the courts in deciding whether or not parental failure to provide medical care for their child constitutes neglect within the meaning of the statute and, therefore, justifies commitment of the child and an entry of the order for the indicated medical treatment.

For example, the court will consider whether the

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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W. B. Saunders Company, 1959, p. 395.

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Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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failure to provide medical treatment is likely to result in the death of the child. If the child's life is at stake, the courts more frequently overrule parental objections and order the needed care. If some lesser degree of peril is involved or if no present emergency really exists, courts may refuse to intervene.

More often than not, however, even when the courts find that no imminent danger threatens the child's life, it will nevertheless find that the danger of gross deformity or mental incompetence, which might result from failure to carry out the needed treatment, is sufficient basis to sustain a finding of neglect.

Further, the court considers also whether the treatment itself will involve any risk to the life or health of the child. If the risk that the treatment may not be successful is substantially great and may cause the child's death or a more severe handicap than existed prior to the operation, the courts are disinclined to interfere. In such cases, the parents are allowed a greater degree of discretion in deciding whether or not to submit the child to this greater risk. If, however, the prognosis for recovery is favorable and all other factors are favorable, the courts will not hesitate to order treatment.

In addition, some consideration is given to the question of whether the treatment might be expected to have an adverse psychological effect on the child. At least one New York case indicates that when such a possibility exists, the court will not order treatment over the parent's objection. Quite possibly, the converse of this would be true also.

Also, although the parents are allowed considerable discretion in the custody, care, and control of their children, and although the courts will give their rights as parents every consideration, yet even greater importance is attributed to the right of the child to live and, whenever possible, to live a healthy, happy, useful life in which, hopefully, he can be self-supporting. A parent is not permitted to allow his own personal convictions to cause the death of the child or to ruin his child's chances for a normal life.

Finally, there is the consideration that it is to the State's interest to see that the children become normal, useful citizens rather than public wards. This interest may override parental rights if parental action is detrimental to the child's health and welfare.

The factors I have mentioned are merely general considerations. Nowhere, to my knowledge, are cases more highly individualized than in this area. Nowhere is the necessity for deciding each case on its particular facts more important. The slightest variation of facts in one instance may justify results completely different from that reached in another.

Only one general proposition may be stated with complete certainty: The courts will not tolerate abuse or neglect of children, and the State, through its courts, will protect its youth and will do so jealously.

There is a very important problem inherent in any restraint of a natural right, a problem I have avoided up to this point, viz., the constitutionality of our statutes and the procedures under them. When religious scruples are the basis for parental refusal to submit their child to medical care, is it not a denial of religious freedom, guaranteed by the First and absorbed into the Fourteenth Amendment of the Federal Constitution, to order medical treatment contrary to the wishes of the parents?

As many times as this question has been ruled upon by state appellate courts, I have yet found no case which has reached the Supreme Court of the United States. I understand that there is one before it now, and Mr. O'Donnell will discuss it with you. I am certainly waiting with anxious anticipation to hear what the Supreme Court will say; but at the moment, state courts, it seems to me, have answered the constitutional objections rather adequately.

The First Amendment of the Federal Constitution forbids Congress "to make any law respecting the establishment of religion or prohibiting the free exercise of religion." The Fourteenth Amendment, as I have already suggested, has been construed by the Supreme Court as making the provisions of the First Amendment equally applicable to the states.

Courts in this country have, in general, recognized that religious freedom comprehends two separate concepts: first, the freedom to believe, and, second, the freedom to act.

Without exception, freedom of religious belief is held to be absolute, subject to no restraints by the states. Freedom to act upon one's religious beliefs, however, is subject to regulation for the protection of society. The state is charged with the duty not only to preserve individual liberties guaranteed by the Constitution but also to protect

society in general from danger. When one's exercise of his personal rights unduly interferes with the legal rights of others, it is generally agreed that some form of restriction upon personal action is in order.

When the state enacts laws to protect the public health, welfare, and safety, it is said to be exercising its police powers. Although the police power itself of the state no longer seems to be subject to any serious controversy, problems still arise occasionally as to the scope and extent of that power. Generally, laws enacted pursuant to the police power of the state are accorded liberal construction. The only significant limitation imposed upon the state in this respect is that such laws, the so-called police power laws, must not be so unreasonable and extravagant as to interfere unnecessarily and arbitrarily with the property and personal rights of citizens. Whether or not a state law is invalid because it violates this limitation can be determined only on a case-by-case basis.

A number of state court cases have considered the constitutional objections raised against laws imposing a duty upon parents to provide medical care for their minor children and providing procedures to assure that abuses of this duty are corrected. These cases have held that the enactment and enforcement of such laws are within the police power of the state and not violative of the petitioner's religious freedom or any other constitutional right. Such was the holding of our own Court of Appeals in 1959 in the Craig case in which, on the ground that it conflicted with their religious beliefs, the parents refused medical aid to a child who was ill with pneumonia and who subsequently died.

In that case, in answer to the contention that the defendants' freedom of religion had not been respected, the court said:

> In prosecuting for the breach of duty imposed by statute to furnish necessary medical aid to a minor child, the particular religious belief of the person charged with the offense constitutes no defense. He cannot, under the guise of religious conviction, disobey the laws of the land made for the protection of the health and safety of society.

The court continued, saying that the State of Maryland was vitally concerned with the health and safety of its children and in the obedience of its children to its laws. The parents were at perfect liberty to believe in the religion of their selection. They might pray, anoint, or call in the elders of their church in case of sickness of their minor children; but they, like all parents, must also obey the mandate of Article 72A, Section 1, by providing medical aid when the circumstances properly require it.

In an Illinois case (People v. Labrenz, 104-NE2d769, 1952) which is discussed in an interesting and well-written little article, entitled "Parens Patriae," in the November, 1954, *New England Journal of Medicine,* the Supreme Court of Illinois answered the religious objection in more or less the same way as the Maryland Court, saying this:

> Concededly, freedom of religion and the right of parents to the care and training of their children are to be accorded the highest possible respect in our basic scheme. But neither the rights of religion nor the rights of parenthood are beyond limitation. Indeed, the early decisions in the Reynolds case, upholding a Mormon's conviction for bigamy against the defense of interference with religious freedom as guaranteed by the First Amendment, leaves no doubt about the validity of the action taken here. Laws are made for the government of actions and, while they cannot interfere with mere religious belief and opinions, they may with practices.

The decisions of the state courts in the child-neglect cases and in other similar cases find authority in early decisions of the Supreme Court in related areas. There are two leading decisions of the Supreme Court that enunciate the principles usually invoked to sustain governmental regulation for the protection of public health, welfare, and safety.

The first case dealt with the power of the state to compel vaccination of its inhabitants (Jacobson v. Mass. 197 U.S. 11, 1905). The second (Buck v. Bell, 274 U.S. 200, 1927) concerned compulsory eugenic sterilization of a mentally defective. In each, the state's action was held not to be a denial of due process.

In each of these cases the constitutionality of the police powers of the state was questioned. In each, the Supreme Court held that public health and welfare would be served by the statutes in question and that a public good could be shown which would empower the state to subordinate the rights of the individual involved to the public purpose to be accomplished.

There have been a number of cases in which statutes have been upheld even though they prohibited certain religious practices. Among them were polygamous marriages, selling of religious papers, possession of a drug called peyote, which apparently was part of the religious practices of a particular group, and fortune-telling, even

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1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

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though done by a minister of a particular religious sect as part of religious practice.

Most directly in point, I believe, is the language of the Supreme Court in another case, Prince vs. Massachusetts [321 U.S. 158, 1944]. Here was upheld a conviction of a Jehovah's Witness for permitting her minor ward to sell religious articles on the street in violation of a local ordinance prohibiting children from engaging in this kind of activity. It was held that the statute did not abridge freedom of religion. The Supreme Court, in the opinion, made the following comment, which seems applicable with equal force to the question of the constitutionality of statutes providing for compulsory medical care for infants:

> But the family itself is not beyond regulation in the public interest as against a claim of religious liberty. And neither rights of religion nor rights of parenthood are beyond limitation. Acting to guard the general interest in youth's well-being, the State, as *parens patriae,* may restrict the parents' control by requiring school attendance, regulating or prohibiting child labor, and in many other ways.
>
> The right to practice religion freely does not include liberty to expose the community or child to communicable disease, or the latter to ill health or death. . . . Parents may be free to become martyrs themselves. But, it does not follow that they are free . . . to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.

In summation, the natural rights of the parents to the custody and control over the minor child must yield in certain instances to the power of the state. The state's power in this respect is based upon three foundations: 1) on its position as *parens patriae* for the sovereign's right of guardianship of persons under a disability; 2) on the right of a child as a citizen and a ward of the state to its protection; and 3) on the state's self-interest in its own perpetuation.

Mr. O'Donnell: It seems to me that the fundamental consideration in connection with this subject matter is in the question of consent.

There are two extremes relating to physical contact by others: a person takes the greeting of a clap on the shoulder and the jostlings of a fellow pedestrian as part of existence in society and is not permitted to clutter up the law courts with suits merely because he did not like to have such physical contact made. The applicable principle of law here involved might be expressed by saying that the law gives "no right" to the one so touched or jostled, or that he impliedly "consented to such act."

At the other extreme are physical contacts, intentionally made and in a variety of circumstances, which are of a serious nature: assaults with intent to murder, with intent to rob, with intent to rape, and even those indecent liberties which are taken and those batteries which the law recognizes as criminal.

Somewhere in between these extremes are the treatments given and operations performed by physicians and surgeons. The basic principle is that a doctor has no right to act without the consent of the patient, or, from the other point of view, a patient may give or withold permission in respect to treatment or operation. Difficult legal questions then arise as to what amounts to express consent, when can the consent be implied, and what acts constitute violations of this legal principle.

An explanation of the interlocking legal and practical aspects of the problem undoubtedly date back to the days of surgery before the development of anesthetics. We can all picture the crude diagnosis and type of operation undertaken by village barbers and others who practiced medicine in those days. One can even visualize the patient, if you may call him that, being held down by his friends on a crude table after receiving a stiff drink of whiskey. As the surgery progressed, the operator might, for the first time, discover conditions indicating a different operation or a more extensive one than had been contemplated. In those circumstances—although admittedly subject to inconveniences—it would have been possible to advise the patient of the facts and procure his consent to a change. The principle of consent became controlling.

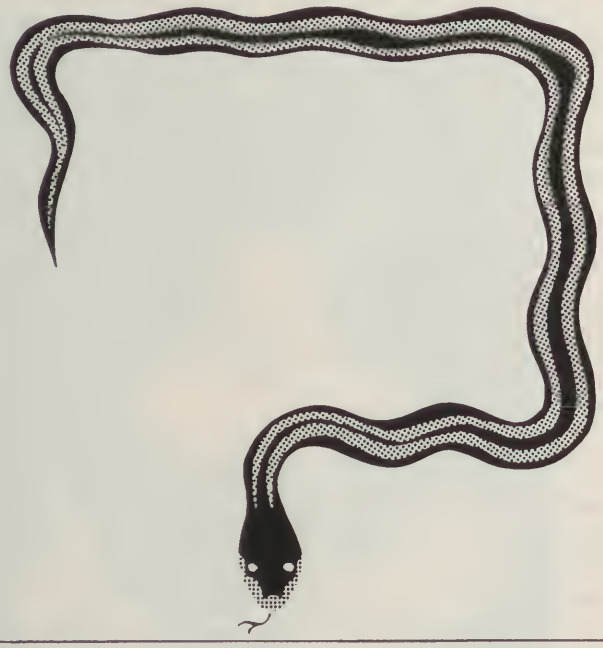
In time, diagnostic skills increased, as they are increasing today, and anesthetics came into use; but undoubtedly, even today, there are circumstances in which examination under anesthesia permits a diagnosis which would not otherwise have been practicable or possible; progress in a surgical operation may reveal conditions which were not anticipated but which require attention and correction.

The courts have held that ordinarily the patient must be consulted and his consent given before a physician may operate on him.

The reasoning of the law is pointed out in a Minnesota case, in *Mohr* v. *Williams.* This was decided in 1905. The court held that:

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Under a free government, a citizen's greatest right is to the inviolability of his person and this right necessarily forbids a doctor who has been asked to examine, diagnose and advise, to place a patient under anesthesia for an operation without the knowledge and permission of the patient.

The court in its opinion stated:

There is logic in the principle thus stated, for, in all other trades, professions, or occupations, contracts are entered into by the mutual agreement of the interested parties and are required to be performed in accordance with their letter and spirit. No reason occurs to us why the same rule should not apply between physician and patient. If the physician advises his patient to submit to a particular operation, and the patient weighs the dangers and the result incident to its performance, and finally consents, he thereby, in effect, enters into a contract authorizing his physician to operate to the extent of the consent given, but no further.

The court then pointed out that when a patient understands the nature of the condition to be corrected, a doctor is allowed a wider latitude of discretion in his treatment and may go farther in cases of emergency. Emergencies may arise prior to or during the course of the operation.

Of course there are some circumstances when consent is said to be "implied"; this is another way of saying that although no express consent was given by the patient, it would not be required. When a patient presents himself for diagnosis and treatment and accepts that which is given, although nothing has been said about it, there is a legal presumption that he has consented. A form of consent, whether it be classed as "express" or "implied," occurs when a patient indicates his condition generally to the doctor and in effect says to him, "Take care of it."

Treatment rendered or an operation performed in an emergency falls within the rule of implied consent, although such treatment or such operation may not be more extensive than reasonable and necessary.

The doctrine of implied consent has been extended to emergencies when one considers the impracticability of restoring an unconscious patient to consciousness in order to explain to him a need for changing procedures, to then secure his consent, to put him back under anesthesia, and then to proceed as authorized.

To meet some of these limitations, you are familiar with the extensive use of waivers.

Except in cases of emergency, a child is held generally to be incapable of giving consent, and such consent must be obtained from the father. It is doubtful, under the decisions, whether such consent can be given by an aunt or other relative with whom the child may be temporarily residing, as on a vacation.

Consent by a father is not necessary in case of an emergency, although a question may arise as to what facts create the emergency. A clear case of emergency existed when a 15-year-old boy had his foot crushed by a train and was found unconscious. The surgeon who amputated without the consent of either the boy or his father was held by the Michigan courts not to be liable.

In a New York case, *Sullivan* v. *Montgomery*, decided in 1935, the question was discussed of the consent by a minor, 20 years of age, who fractured his ankle playing baseball. The court in that case said, as part of its opinion:

While the courts are not entirely in harmony upon the question of consent to the administration of an anesthetic, the better reasoning supports the proposition that if a physician or surgeon is confronted with an emergency which endangers the life or health of the patient, or that suffering or pain may be alleviated, it is his duty to do that which the occasion demands within the usual and customary practice among physicians and surgeons in the same locality. Many persons are injured daily in our city, and emergency cases constantly arise. To hold that a physician or surgeon must wait until perhaps he may be able to secure the consent of the parents, who may not be available, before administering an anesthetic or giving to the person injured the benefit of his skill and learning, to the end that pain and suffering may be alleviated, may result in the loss of many lives and pain and suffering which might otherwise be prevented.

The court continued:

I do not believe that those who have devoted their lives to humanity will wantonly administer an anesthetic or fail to obtain the consent of the parents before administering an anesthetic where such consent may be reasonably obtained in view of the emergency; it would be altogether too harsh a rule to say that under the circumstances disclosed by the testimony in the instant case, the defendant should be held liable because he did not obtain the consent of the father to the administration of the anesthetic; as the defendant was confronted with an emergency, and as he obtained the consent of his patient, I hold that the consent of the father was not necessary.

Of course, in this case, the minor was 20 years of age.

A different point of view was pointed out in a District of Columbia case decided in 1941, *Bonner* v. *Moran*. The mother of a 15-year-old boy was ill, and he was living with an aunt and cousin away from the mother's home. The cousin was crippled as a result of burns and it was felt that

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a skin graft would help her condition. Without notifying the mother, the aunt made arrangements with a surgeon who attempted a graft from the boy to the cousin. The child remained in the hospital for two months. The court commented on the fact that even though the boy could have understood the nature of the operation, there was no evidence that it had been explained to him. It was held that the consent of the aunt was legally insufficient. The court in its opinion said:

> In the great majority of the states, the question seems never to have arisen, nor are there any federal cases on the subject. However, the general rule is that the consent of the parent is necessary for an operation on a child.
>
> We think that there can be no doubt that a surgical operation is a technical battery, regardless of its results, and is excusable only when there is express or implied consent by the parents; or, stated somewhat differently, the surgeon is liable in damages if the operation is unauthorized. Here, as we have already seen, the question is whether the consent of a boy 15 years of age dispenses with the necessity of consent by his parents. The trial court decided that it did. . . . In deference to common experience there is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decisions, as the result of which public policy demands legal protection of their personal as well as their property rights. . . . Hence it is not at all surprising that, generally speaking, the rule has been considered to be that a surgeon has no legal right to operate upon a child without the consent of his parents or guardians.
>
> There are, of course, exceptions to this rule. One is in the case of emergency, when obviously an operation is necessary; others perhaps in cases in which the child had been emancipated (reached the legal age) or where the parties are so remote as to make impracticable the obtaining of their consent in time to accomplish proper results. And when the child is close to maturity, it has been held that the surgeon may be justified in accepting his consent.
>
> But in all such cases the basic consideration is whether the proposed operation is for the benefit of the child and is done with the purpose of saving his life or limb. The circumstances in the instant case are wholly without the compass of any of these exceptions. Here the operation was entirely for the benefit of another and involved sacrifices on the part of the infant of fully two months of schooling, in addition to serious physical pain and possible results affecting his future life.

As we have seen in the great majority of cases where this problem has come to the courts, it has involved minors, those who legally are considered incapable of entering into a contract and thus incapable of legally consenting.

Since, too, we have seen from those cases cited that generally a minor can be said to have impliedly consented in cases of emergency, resort has been made to the courts for a judicial determination that an emergency does in fact exist. It is fairly easy to work out the rationale of the action of the courts in cases of minors under the always present legal principle that the court will do that which is in the best interests of the minor.

When we come into the area of the power of the state to impose medical treatment—immunizations and general medical care on one who is *sui juris*—the problem is much more difficult.

That the state has the right to protect life cannot be seriously questioned. Self-destruction or, if you will, suicide was a felony under English Common Law. The lands and goods of the offender, as in the cases of other felonies, were forfeited to the king and the body was ignominiously buried in the highway. The suicide was deemed a felon, the murderer of himself. You may whimsically be asking yourselves: How did the state prosecute a suicide? Obviously there was no prosecution, but his lands and goods were forfeited, as were those of any other felon. Attempts to commit suicide were, however, indictable as an attempted felony, and those who aided, abetted, and assisted in the commission of the suicide or attempted suicide were indicted, tried, and convicted.

An early English case, *Rex* v. *Dyson*, decided in 1823, held that if two persons entered into a suicide pact, that is, if they mutually agreed to kill themselves, respectively, or one to kill the other, and the means employed by them took effect only upon one, the survivor was held to be guilty of the murder of the one who died.

Chief Justice Gray, in the case of *Commonwealth* v. *Mink*, decided in Massachusetts in 1877, said this:

> Suicide being unlawful and criminal, as *malum in se*, any attempt to commit suicide is likewise unlawful and criminal. Everyone has the same right and duty to interpose to save a life from being so unlawfully and criminally taken, that he would have to defeat an attempt unlawfully to take the life of a third person. . . . And it is not disputed that any person who, in doing or attempting to do an act which is unlawful or criminal kills another, though not intending his death, is guilty of criminal homicide, and at least manslaughter.

Closely akin to the prohibition against the affirmative taking of one's life, the law also punishes those who by acts of criminal omission cause one to die. Criminal responsibility in such situations arises only when there is an omission of a *legal* duty owned by the defendant to the deceased and such omission was the proximate cause of the death. The indispensable ingredient for criminal liability in such cases is the existence

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of a legal duty toward the person suffering the harm.

The abstention of a bystander who remains passive while a murder is committed in his presence is an insufficient fundamental ingredient for criminal liability in such cases. Failure to perform acts of mercy or the shirking of moral obligations do not alone, without a legal duty flowing from the accused toward the deceased, supply the underpinnings for criminal liability. The case of *Regina* v. *Instan,* a Queen's Bench decision in 1893, illustrates the point very well:

The unmarried defendant was living with an aunt 73 years of age and was maintained by her. They lived alone in the household unattended. Shortly before her death, the aunt became incapacitated by a gangrenous leg, was virtually immobilized, and was incapable of helping herself. No one knew her condition but the defendant; she continued living in the house at the cost of the deceased, using food supplied them by the tradespeople. The niece gave no food to her aunt and failed to provide medical and nursing attention to her. Although the niece frequently spoke with her neighbors, she made no mention whatsoever unto them of the condition of her aunt. The cause of death was listed as "exhaustion caused by the gangrene, but substantially accelerated by neglect, want of food, of nursing, and of medical attendance." Her conviction by a jury was upheld by the Queen's Bench in an opinion by Lord Coleridge, who said:

> It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on moral obligation. A legal common law duty is nothing else than the enforcing by law of that which is a moral obligation without legal enforcement. There can be no question in this case that it was the clear duty of the prisoner to impart to the deceased so much, as was necessary to sustain life, of the food which she from time to time took in, and which was paid for by the deceased's own money for the purpose of the maintenance of herself and the prisoner; it was only through the instrumentality of the prisoner that the deceased could get the food. There was, therefore, a common law duty imposed upon the prisoner which she did not discharge.

The lack of a legal duty to act is pointed out in a Michigan case, *People* v. *Beardsley,* decided in 1907—and I might say, parenthetically, we used this case in connection with our investigation as to whether or not we had any criminal action to be brought in connection with the death of "Big Daddy" Lipscomb.

In this case, a manslaughter conviction against the defendant was set aside. The deceased female, 30 years of age, had previously made assignations with the defendant, a married man. At the time of the fatal episode, she had gone to his apartment with him and they had engaged in a prolonged drinking bout, toward the end of which she obtained some camphor and morphine tablets. Although the defendant physically attempted to prevent her from taking the tablets, she managed to swallow three or four grains of morphine. When the woman was reduced to the state of stupor, the defendant had another person assist him and removed the woman to the bed in another apartment. The other tenant, who had agreed to look after her, became alarmed at her condition, summoned a physician, and she was pronounced dead.

The prosecution made no claim that the defendant, Beardsley, had in any way been an active agent in bringing about her death but contended that he owed her a duty, failed to perform it, and in consequences of the failure she died.

On appeal his conviction was reversed, the court holding that there was no legal duty founded solely on a moral obligation and that the defendant was under no legal duty toward the woman to make a reasonable and proper effort to save her.

Mr. Justice Field, in giving the opinion of the court, said:

> In the absence of such (legal) obligations, it is undoubtedly the moral duty of every person to extend to others assistance when in danger; . . . and if such effort should be omitted by anyone when they could be made without imperiling his own life he would by his conduct draw upon himself the just censure and reproach of good men; but this is the only punishment to which he would be subjected by society.

There are other relationships which impose upon one the legal duty of providing medical attention for another, and the omission or neglect to perform this duty when attended with fatal results will render the one upon whom the duty is imposed liable to indictment and conviction for manslaughter; these involve cases where a woman who was acting as a "baby sitter" for compensation neglected to obtain needed care for the infant, a master who failed to provide medical care for his ill house servant, and a friend who aided and abetted a father in his neglect to provide medical attention for his sick child.

The liability to conviction in homicide cases, because of a failure to provide medical attention, is sometimes made to depend upon the question

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PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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of whether or not such medical attention is a "necessary" within the meaning of statutes requiring defendants to provide necessaries for the deceased.

In the *Craig* case, referred to by Professor Farinholt, the child became ill and died several days later of pneumonia. The parents were members of a sect which believed in calling in the elders of the church in prayer and in the "laying on of hands" to cure an illness. The Craigs followed all of these religious procedures but did not summon in medical aid, and the child died. They were convicted by the Circuit Court for Washington County of manslaughter, but the conviction was reversed by the Court of Appeals.

The Court held that Article 72A, Section 1, of the Maryland Code, which charges parents with the "support, care, nurture, welfare, and education" of their minor children embraced as well the obligation to furnish medical care.

With the overtones of religious principles throughout the case, the Court of Appeals reversed the conviction because of the insufficiency of the evidence offered to show that the parents were guilty of gross or wanton negligence, as distinguished from ordinary negligence, in failing to seek medical care at the onset of the child's illness. And because it appeared that by the time the gravity of the child's illness became discernible, medical aid would probably have been ineffective, the Court said it was not established that the negligence of the parents, even if considered gross and wanton at this later time, was in fact the proximate cause of the death of the child.

Defenses to the charge of manslaughter for the failure to render necessary medical attention have generally been on three gounds: 1) as being contrary to religious belief; 2) by calling in a person other than an authorized physician; and 3) financial inability to provide the required attention.

As a general rule, as Professor Farinholt pointed out, religious belief is no defense to a prosecution for manslaughter where death results from want of medical attention on the part of the defendant who is under a legal duty to furnish it. These cases, however, nearly all involve the parental failure to provide medical care for children.

In some other cases, the defense has been made that an individual other than a legally licensed physician has been called in to attend. Although there is a division among the legal authorities, it seems to be the consensus that the calling in of one who has some knowledge of the curative art, or even the summoning of a Christian Science practitioner, is no legal defense to such a charge.

The financial inability to provide needed medical attention on the part of the person who was under a legal duty to provide such attention has often also been raised as a defense. Such financial inability to provide needed food, medicine, and medical care can be a defense, but only when the evidence shows that there are no public authorities available to whom application could be made for financial assistance. Again, nearly all of the reported cases in these areas involve the parent-child relationship.

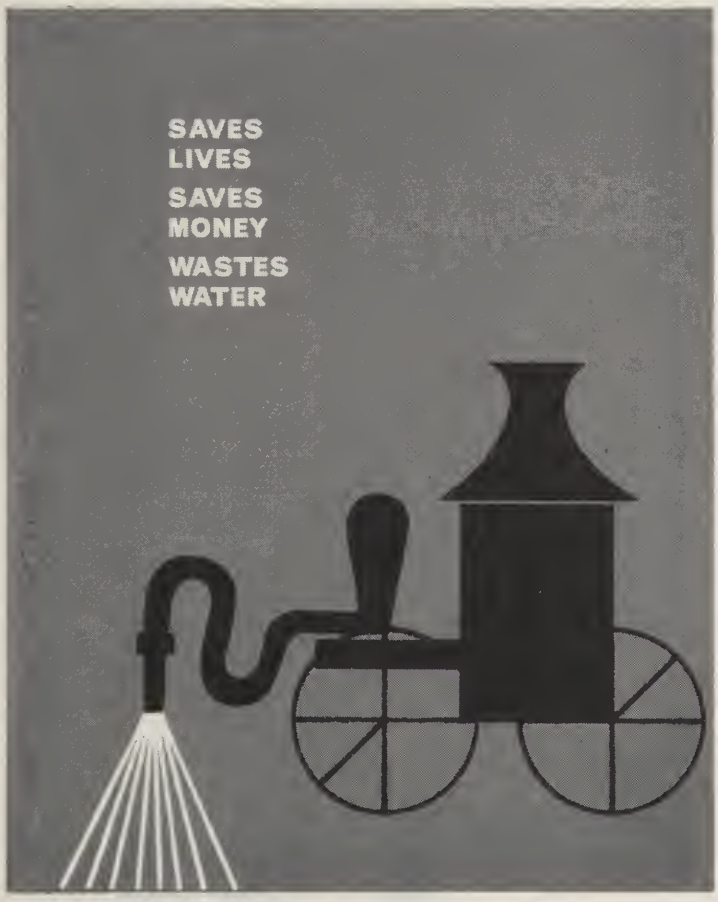
We are all familiar with those statutes requiring vaccinations, physical examinations prior to the issuance of marriage licenses, and quarantine and isolation of those with communicable diseases dangerous to the public health.

The Baltimore City Code makes one guilty of a misdemeanor who refuses or neglects to be properly quarantined and isolated when suffering with a communicable disease or who, by reason of noncooperation or carelessness, endangers the public health. It is to be noted, however, that the City Ordinance does recognize, in this connection, religious beliefs: for it says that the provisions of the ordinance shall not be construed to interfere with bona fide practicing Christian Scientists or those who are under treatment from registered Christian Science practitioners.

Article 12, Section 209, of the City Code requires parents and guardians to have their children and wards vaccinated before they attain the age of one year and revaccinated whenever the Commissioner of Health requires it after five years from the last vaccination.

Article 43, Sections 70 and 73, of the Maryland Code make it unlawful for a medical practitioner to refuse to vaccinate any person or for any teacher in any public school to receive into such school a pupil who has not been vaccinated.

In 1952, the State of Washington upheld the validity of a regulation requiring students registering for admission to the state university to submit to a chest x-ray for tuberculosis. In *State ex rel. Holcumb* v. *Armstrong,* the court held that a regulation requiring such students registering for admission to the university, as applied to a Christian Scientist student, did not violate the guarantees of religious freedom contained in the state



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and federal constitutions. The court said that while freedom of religious belief was absolute, freedom to act in pursuance of such religious beliefs must, in the nature of things, remain subject to regulation for the protection of society.

So again, as in the *Craig* case and the *Levinsky* case in Maryland, the court says: We recognize the absoluteness of the right to a religious belief, but we also recognize the limitation of a right to act based upon that religious belief.

Statutes setting up procedures for discovering and for treating sexual psychopaths, which require, obviously, as part of the procedure, physical and mental examinations of persons reasonably suspected of being so inflicted, have been sustained both in California and in Missouri on the grounds of attacks on various constitutional grounds.

The recent decisions of the courts have continued to recognize that the interests of the community in protecting the general health (this is under the Tenth Amendment to the Constitution) justifies some interference with the liberty of the citizens and attempts made to avoid compliance with reasonable regulations requiring physical examinations, on the grounds that such compulsory examinations violated constitutional rights and privileges, have generally been unsuccessful.

We have here in Maryland our own statute defining "defective delinquency" and ordering the commitment to Patuxent Institution of those who appear to fit the classification, for physical and mental examination, to determine whether or not they are defective delinquents.

Rule 420 of the "Maryland Rules of Procedure" provides:

> Whenever the mental or physical condition or the blood relationship of a party or of an agent or a person in the custody or under the legal control of a party, is material to any matter involved in any action, the court may, upon motion by any party and notice to all other parties, for good cause shown, order such party to submit to a mental or physical or blood examination by a physician or physicians or to produce for such examination his agent or to produce the person in his custody or legal control.

In paternity cases, under the provisions of Article 12, Section 20, of our Code, a defendant who denies paternity can obtain a court order requiring not only that he but the mother of the child and the child itself submit to a blood test to determine whether or not, from blood groupings, the defendant can be excluded from being the father of the child. The statute permits a reference to be made in the evidence that either the complainant or the child failed to submit to such blood test.

Article 16, Section 44, of the Maryland Code pertaining to "inebriates" permits any person to petition the court for leave to commit a habitual drunkard to a state institution for the medical treatment of drunkenness. The statute, however, provides that in any such petition for commitment it must set forth that the drunkard is willing and will agree to attend such institution and must in writing agree to take such treatment.

The provisions of law relating to the power to commit persons *non compos mentis* are familiar to all.

Now, with all this background, you are saying in your minds: So what?

There is presently pending, on application to the Supreme Court of the United States, a petition for the issuance of a Writ of Certiorari, the case of *Jessie E. Jones* v. the *President and Directors of Georgetown College, Inc.* This case involved an adult who, because of her religious belief, refused to permit a blood transfusion. This case meets, if you will, head on the question we now have before us this evening of whether or not the court has the power to intervene and order a blood transfusion for an adult who is opposed to such transfusions on religious grounds.

The facts: On September 17, 1963, Mrs. Jessie Jones, 25 years of age, a Negress and the mother of a seven-month-old child, awoke feeling extremely ill. Her husband took her by taxicab to Georgetown University Hospital; she had no personal physician and submitted herself solely to the responsibility of the hospital staff. Examination confirmed that she had lost two-thirds of her body's blood supply from a ruptured ulcer. Her hematocrit was tested in midafternoon at 14%. The doctors who attended her, as her condition worsened, were convinced that she would die unless she was given an emergency blood transfusion.

Both Mr. and Mrs. Jones were Jehovah's Witnesses. Their religion teaches that it is a sin "to consume blood," and they refused to permit the transfusion. The basis for their religious opposition to blood transfusion is that in receiving a transfusion, one is really eating blood. And they rely on two biblical passages: Genesis 9:2, where God told Noah, after the flood, "Every creeping animal that is alive may serve as food for you. As in the case of green vegetables, I do give it all

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to you. Only flesh with its soul—its blood—you must not eat"; again in Leviticus 17:10, God tells of the consequences of disobedience. "I shall certainly set my face against the soul that is eating the blood and I shall indeed cut him off from among his people."

When the hospital authorities could not prevail upon either Mrs. Jones or her husband to permit the transfusion, the attorney for the hospital made an application to the U.S. District Court for a court order permitting the transfusion. Judge Tamm, of the District Court, denied the application and refused to act. Counsel went immediately, about 4 PM that same day, to Judge J. Skelly Wright, of the U.S. Circuit Court of Appeals for the District of Columbia. The judge spoke by telephone with the attending physician and then went to the hospital.

Mr. Jones advised him that he would not approve the blood transfusion on religious grounds but that if he, the judge, ordered it, Mr. Jones's responsibilities, morally and religiously, were relieved.

The judge obtained permission of Mr. Jones to see his wife. Her appearance confirmed the urgency of the situation. The judge tried to communicate with her to advise her of what the doctors had said. Her only audible reply was, "Against my will." Judge Wright concluded that she was not in a mental condition to make a decision and, after additional efforts to persuade Mr. Jones to authorize the transfusion, pointing out to him that blood administered by transfusion was different from "drinking blood," even though Mr. Jones remained unmoved, the judge ordered the transfusion.

Mrs. Jones recovered. She acknowledges that the transfusion may have helped her, but she says, "No one knows the secret of life and death." She stated that even if it did help her, such action did not justify violating her religious beliefs.

On October 14, the patient filed a petition with the U. S. Circuit Court of Appeals for a rehearing and for an order setting aside the order signed by Judge Wright authorizing the transfusion. The nine judges of that Court refused to grant a rehearing—and nearly every one of them had a separate and different legal reason—and the application is now pending before the Supreme Court to review Judge Wright's action and the action of the Court of Appeals in denying a reopening of the case.

Judge Wright's opinion sums up the issue we have here and will help to give some of the legal thinking that went into the case. In his memorandum opinion, he stated that at the time the application was made to him, the court was familiar with similar cases respecting children but was unaware of any precise legal precedent for its action in connection with a 25-year-old adult. So this case is a case of, you might say, unprecedented action.

Judge Wright found, because of the demonstrated imminence of death from loss of blood, the order was necessary to maintain the *status quo* and to prevent the issue respecting the rights of the parties from becoming moot. He held that the case did not involve a person who for religious or other reasons had refused to seek medical advice; nor did it involve a disputed medical judgment or a dangerous or crippling operation. Nor did it involve the delicate question of saving a newborn in preference to saving the mother. Mrs. Jones had sought medical attention and had placed on the hospital the legal responsibility for her proper care. In its dilemma, not of its own making, the hospital sought judicial direction.

In his opinion, Judge Wright said:

> It has been firmly established that the courts can order compulsory medical treatment of children for any serious illness or injury and that adults, sick or well, can be required to compulsory treatment or prophylaxis for contagious diseases and that there are no religious exemptions from such orders.

This is the only area in which we have had precedence. He cited from the decision of the Supreme Court in *Prince* v. *Massachusetts*:

> . . . Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parents' control. . . . Its authority is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience. Thus, he cannot claim freedom from compulsory vaccination for the child more than for himself on religious grounds. . . . The right to practice religion freely does not include liberty to expose the community or the child to communicable disease or the latter to ill health or death.

He further pointed out the decision of the Supreme Court in 1878 in *Reynolds* v. *U.S.*, that if a wife religiously believed that it was her duty to burn herself upon the funeral pyre of her husband, it was not beyond the power of the government to prevent her from carrying this belief into practice. He pointed out also the decision of the Supreme Court in 1905 in *Jacobson* v. *Massachusetts*, where the Court upheld the power



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of the state to subject adults, against their will, to be vaccinated.

In Judge Wright's opinion, he recognized that the facts involved neither a sick child nor a contagious disease but that the case was analogous to the sick children cases because Mrs. Jones was *in extremis* and was hardly *compos mentis*—that she was as little able competently to decide for herself as any child would be. He concluded that the Court had the responsibility of assuming guardianship for her, even though she was an adult, as it would be for a child, at least to the extent of authorizing treatment and, I quote from his opinion, "to save her life." By analogy, he found that since a parent has no power to forbid the saving of his child's life, *a fortiori* the husband of the patient had no right to order the doctors to treat his wife in a way that would cause her to die.

The state, as *parens patriae,* will not allow a patient to abandon a child, and so it should not allow this ultimate of voluntary abandonments in permitting her to die and, thus, abandon her seven-month-old child; just as she had a responsibility to the community to care for her infant, the people had an interest in preserving the life of the mother.

Judge Wright disposed of the argument submitted to him that an individual's liberty to control himself and his life extended even to the liberty to end his life by pointing out that self-homicide, suicide, was a crime, and that the refusal to have necessary medical aid could be construed as attempting suicide, the only difference being between misfeasance and nonfeasance.

Judge Wright, in part of his opinion, said:

> The Gordian knot of this suicide question may be cut by the simple fact that Mrs. Jones did not want to die. Her voluntary presence in the hospital as a patient seeking medical help testified to this. Death, to Mrs. Jones, was not a religiously commanded goal but an unwanted side effect of a religious scruple. There is no question here of interfering with one whose religious convictions counsel his death, like the Buddhist monks who set themselves afire. Nor are we faced with the question of whether the state should intervene to reweight the relative values of life and death after the individual has weighed them for himself and found life wanting. Mrs. Jones wanted to live.

The third set of considerations involving his decision related to the position of the doctors in the hospitals. She submitted herself to the hospital for treatment; they had no choice but to administer proper treatment or to let her die in a hospital bed and expose themselves and the hospital to both civil and criminal liability. He concluded that Mrs. Jones did not have the authority, when she submitted herself to the hospital for care, to place the hospital and its doctors in this impossible choice.

His opinion concluded:

> Neither the principle that life and liberty are inalienable rights nor the principle of liberty of religion provides an easy answer to the question whether the state can prevent martyrdom. Moreover, Mrs. Jones had no wish to be a martyr. And her religion merely prevented her consent to a transfusion. If the law undertook the responsibility of authorizing the transfusion without her consent, no problem would be raised with respect to her religious practice. Thus, the effect of the order was to preserve for Mrs. Jones the life she wanted without sacrifice of her religious beliefs.

It is to be emphasized that the decision of the court in ordering the transfusion was based on two main considerations, as I see it: the utter emergency of the problem and the fact that Mrs. Jones was not considered fully *compos mentis.*

Her attorneys have now asked the Supreme Court to review the case on two main constitutional grounds. I might point out to you, in connection with their petition, they have filed two exhibits with the Supreme Court. One is a copy of the magazine, *Awake,* with an article entitled "Does your Child Belong to the State?" Another article published there is: "My Years in Prison in Communist China"; and another exhibit is apparently a pamphlet of the Watchtower Bible and Tract Society, entitled *Blood, Medicine and the Law of God.* These are each filed as exhibits with the Supreme Court, and they are asking the Supreme Court to read these when they consider the legal questions involved.

Her attorneys, in asking the Supreme Court to review this position now, put this on *two* main constitutional grounds: 1) whether a free, adult citizen of the United States has had her constitutional rights violated by a denial to be let alone and her right to determine for herself what will be done to her own body by rejecting a particular form of medical treatment; and 2) whether the First Amendment to the Constitution is violated by forcing a citizen, against her will, to accept a form of medical treatment that is a violation of conscience and religion and whether the Federal Court has the authority to lend its aid in allowing such forced treatment.

Her counsel say in their brief:

> Freedoms of speech, press and religion are entitled

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to a preferred constitutional position because they are of the very essence of a scheme of ordered liberty. They are essential not only to the persons or groups directly concerned but to the entire community. Any interference with them is not only an abuse but an obstacle to the correction of other abuses.

They argue that the Constitution protects her constitutional rights to believe and to act in accordance with the dictates of her own conscience and that there is no power in law or anywhere else to interfere with this right. They point out that persons of Jewish faith abstain from pork; persons of the Roman Catholic faith abstain from meat on certain fast days; persons of Christian Scientist faith abstain from medical care; and the First Amendment protects the individual conscience in all such instances.

The appellants' attorneys, citing from a book published by W. B. Saunders in 1961, *Complications in Surgery and their Management,* and in particular a section entitled "Cumulative Mortality from Complications of Blood Transfusions," point out there are at least 16,500 deaths per year resulting from blood transfusions, according to this work, in pointing out the uncertainty of a good result at the time the court passed its order for the purpose of "saving the life of Mrs. Jones."

They cite further from volume 3 of the *Canadian Bar Journal,* an article entitled "Religion, Medicine and the Law," as authority for their argument that there is much controversy and difference of opinion with the medical profession as to the therapeutic value of blood transfusion.

Her attorneys conclude in their brief that no interest of the public was in any way threatened by Mrs. Jones' refusal to submit voluntarily to a blood transfusion.

In a press interview, Mrs. Jones acknowledged that the hardest question she has had to answer has been the question of responsibility to her infant son. When she was asked, "Didn't you feel an obligation to go on living for his sake, even if it meant a transfusion?" her reply was, "God takes care of the birds, and he clothes the lilies of the field. If he can take care of his inanimate creatures, he can take care of his people who are animate. God would protect him (her son). Besides, he couldn't grow up to be a Christian if I didn't remain one to the end myself."

I think that you may realize, from what both Professor Farinholt and I have discussed with you this evening, that the question of consent permeates the question of the power of the state to impose medical treatment and to order transfusions and immunization. In the case of minors, they are incapable legally of consenting for themselves, and the protection of the courts is invoked to have the court legally give its consent acting for and in behalf of the minor. Resort is also made to the court in order to satisfy the requirement that the hospital, physician, or surgeon is confronted with a genuine emergency.

Cases involving adults are not as easy to dispose of. You will note from Judge Wright's opinion that he found that Mrs. Jones was *in extremis,* thus satisfying the emergency requirement, and that she was legally incapable of giving her legal consent because she was not considered as being fully *compos mentis.*

There can be no difficulty, even with adults, in those areas involving the public health and safety, under the Tenth Amendment. The real difficulty arises in the cases of adults who, because of their personal religious beliefs, refuse to authorize an approved medical procedure.

We will have to await the decision of the Supreme Court as to whether or not the provisions of the First Amendment, freedom of religion, will control in such cases.

I personally doubt that the Supreme Court will agree to review Judge Wright's decision, because actually Mrs. Jones has had the transfusion, she has recovered, and there is no longer a genuine justiciable controversy. If the Supreme Court thus refuses to review the decision, Judge Wright's order becomes an effective precedent based upon the facts with which he was presented. The emphasis must be here made, Mrs. Jones was not fully *compos mentis* and there was a true finding of emergency.

It is questionable whether the doctrine of *parens patriae* could be invoked in the case of an adult whose condition did not present a clear danger to the other members of society unless the theory of the law in punishing self-homicide is made applicable to such cases, although the individual is thus permitting death by negative rather than by positive action.

I am sorry that we cannot give you the precise legal answer which you need and desire, but I trust that what we have said this evening has been thought-provoking and has emphasized for you the areas upon which concentration should be placed when you are confronted with such problems.

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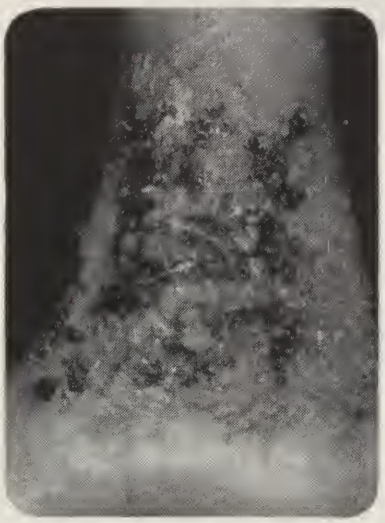
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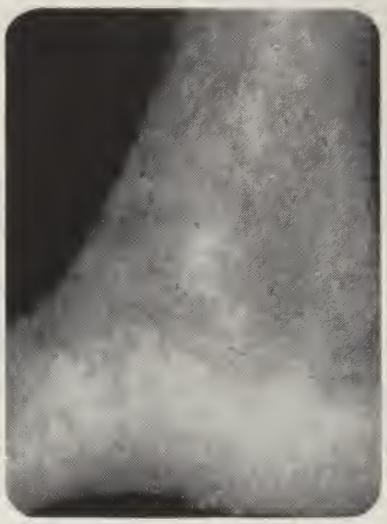
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History of the Baltimore City Hospitals

BY DOUGLAS CARROLL, M.D.



Chapter 6.—The Bayview Asylum: Some Socio-economic Influences (1866-1890)

Society's reaction to the mentally ill has oscillated throughout recorded history between brutality and benevolence. When neither was extreme, pernicious neglect was the rule.[1]

Practices at the Bayview Asylum

The move, in 1866, of the indigent from Calverton to the new three-storey building overlooking the Chesapeake Bay must have been a day of great rejoicing. A number of new rules were drawn up to improve admitting practices and the care of patients. The resident physician was to have control and direction of the medical and surgical treatment of all patients. A number of students were assigned to the various wards under the direction of the resident physician. Students were required to present histories and physical findings on each patient under their care and to keep careful medical records.

In 1871, pay patients were accepted in the institution. In the same year, some of the purchases were: arrowroot, 2,500 cigars, two pairs of handcuffs, medical journals at $25, surgical instruments at $30, 395 pounds of snuff, four dozen bottles of Worcestershire sauce, 957 pounds of tobacco, 75 gallons of whiskey.

The Insane

The crowding of the insane continued to be a problem. In 1879, the Trustees report, "Nothing but callus indifference can be attributed to those whose duty it is to remedy so great an evil." The State Legislature, no doubt, was the target of their barbs, for the Trustees' solution was to have the State of Maryland take responsibility for the insane.

In 1884, a new insane hospital was complete but was scantily furnished with beds, chairs, and other necessities. In this year, two resident doctors were appointed, one recommended by each of the two medical schools (the University of Maryland and the College of Physicians and Surgeons). In 1886, staffing of the insane hospital became the responsibility of the Johns Hopkins University. By 1890, another hospital for the insane had been constructed.

Although the institution must have been overwhelmed with insane patients (it was at this time relieving the state insane asylums at Spring Grove and Mount Hope), the Trustees, in 1890, drew attention to the growing number of patients with chronic diseases. Nearly 80% of the inmates were permanent.

Student Teaching

Medical students had been taught at the Almshouse by professors from a variety of medical schools from around 1812. The quality of the teaching and medical care had varied with the skill and interest of the individual professors. Under Dr. Power, in the 1840's, the instruction and care had been well above average. But these professors had their own practice to attend to. They taught students for a fee or as volunteers. In the early 1890's, the development of the Johns Hopkins Medical School required the use of Bayview for pathological material and for the teach-

ing of psychiatry. The combined interest of the medical schools improved the care of patients.

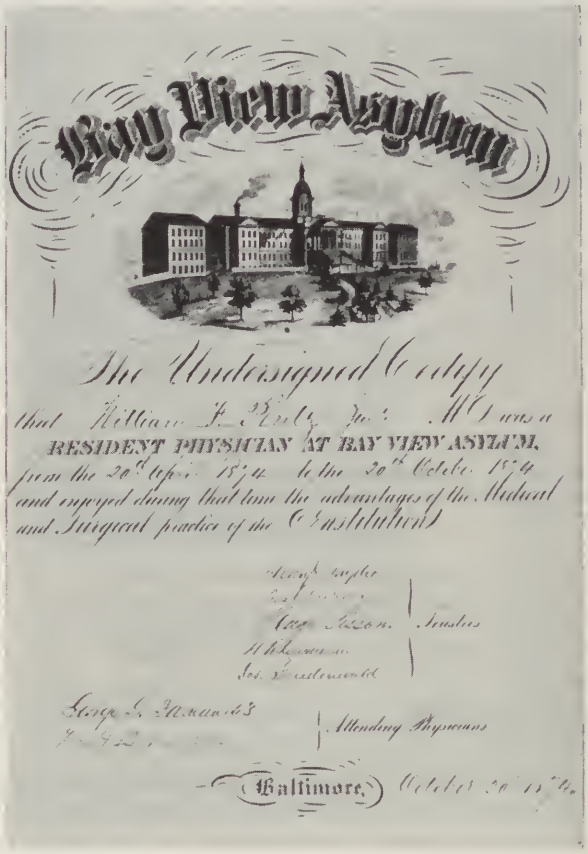
Social Factors Influencing Admissions to the Almshouse

Over the ensuing years, it became more and more a pattern of the municipal courts to admit vagabonds and chronic alcoholics to the Almshouse for domiciliary care. In 1883, the Trustees drew attention to this problem, stating that although the tax payers of Baltimore were perfectly willing to provide for the unfortunate infirm and sick of Baltimore, they objected to providing for the "worthless and dissolute vagabonds" who came to the Almshouse, especially those from other cities. It was not until 1935 that the General Assembly of Maryland took from the magistrates the right to commit persons to the Baltimore City Hospitals unless they were sick. It was recognized at this time that the hospital was not the place for transient vagabonds and alcoholics who were merely without a night's lodging. Such admissions to the hospital in large numbers broke the morale of the staff and resulted in less time for care of the sick.

In 1888, the Trustees first mentioned the possibility that unemployment sometimes resulted from lack of jobs rather than from laziness. They noted that different individuals varied in mental and physical strength. "This, together with the social and moral surroundings, has the effect of making distinct classes." There was an increase in inmates of the Almshouse during this depression year, and the Trustees noted that the older people, the infirm, and those weakened by drink were the first to lose their jobs.

The moral stigma of poverty and unemployment were not lifted until the great depression of the 1930's. There were few, indeed, who were not involved in this major upheaval. It was only by becoming poor that many citizens were able to accept poverty not as a moral indictment but as a result of economic forces.

In 1888, the Trustees demonstrated a good deal of righteous indignation against the oyster industry, which shanghaied workers aboard oyster boats, kept them until they were sick, and then deposited them on shore without pay. In the report of 1888, the fact was clearly established that



Bay View Asylum Certificate 1874

The name of the Almshouse had been changed to Asylum, indicating its function as an insane asylum in addition to its other traditional functions. The building had been completed and opened for use eight years before (1866). This building was refurbished several times, but in 1959 it was completely gutted except for the walls. Five floors were built in the place of the previous three.

a great many of the people coming to the Almshouse came through no fault or failure on their own part.

Cultural and Social Movements Influencing Medical Care

The pattern of small community life was giving way to that of big city life, where contacts between neighbors were not as frequent or friendly, where factories were growing larger and larger, where the men of the family were working in competition in the mareket under employers they did not know personally. A large number of immigrants continued to come into the eastern cities.

William Graham Sumner (1840-1910), professor of political and social science at Yale University from 1872 to 1909, was one of the strongest voices of conservatism. He insisted that poverty was the result of vice and derided the democratic humanitarian ideas of the 18th and 19th centuries as empty speculation. He taught, "A law may be passed which shall force somebody to support the hopelessly degenerate members of a society, but such a law can only perpetuate the evil and entail it on future generations with new accumulations of distress." This philosophy provided a comfortable and supposedly scientific rationale for irresponsibility by the middle and upper classes already becoming more and more impersonal in their community involvement.

This point of view was supported by Herbert Spencer (1820-1930), who said, "Under the natural order of things, society is constantly excreting its unhealthy, imbecile, slow, vacillating, faithless members." The laissez-faire economic system after the Civil War resulted in the accumulation of tremendous fortunes largely through the exploitation of natural resources or through government favoritism.

Nevertheless, during this time, many forces were at work to improve the general medical condition of the community. Although many philanthropists were strongly opposed to any federal or public relief for the sick, they were strongly in favor of private charities to take care of the poor.[2]

The year 1866 marks the beginning of the influence of the public health movement in the United States.[3] Lemuel Shattuck's report in 1859 outlined the needs for public health in Massachusetts and suggested the establishment of state health departments.

In New York City, in 1864, a group of citizens supporting a reform city government uncovered such shocking mismanagement that the New York State Legislature set up a metropolitan board of health in 1866. This led to the development of a health department uninfluenced by patronage and with power to act effectively. This example led to the establishment of other state health departments; Maryland's was founded in 1874.

Other influences were at work. In the insane hospitals, ideas were developing which improved the care of all chronically ill. Dr. John S. Butler (1803-1890), superintendent of the Hartford Retreat in Connecticut, wrote "Curability of Insanity" in 1887. He pointed out the importance of hospital environment and of cheerful, sympathetic people in the care of psychiatric patients. He believed in individual interviews with patients as well as in group discussion. Dr. Butler was extremely interested in person-to-person contact between doctor and patient and attempted to keep the size of mental hospitals to a maximum of 200 patients. He was defeated in this attempt, and throughout this whole period, the individual care and treatment of patients was largely being lost in public institutions.[1]

Family social work had its beginnings in England in 1869 with the founding of an organization which became later the Charity Organization Society. In United States, Buffalo was the first city to have a society of this type in 1877.[4]

Lethargy and indifference characterized the post-Civil War era at the Almshouse. The major problem was the overcrowding of insane patients. No outstanding figure was associated with the Almshouse during this period, and no important advance in medical care is recorded.

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4. Vasey, W.: *Government and Social Welfare.* Holt, Rinehart and Winston, New York, 1963.

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15 mg. Methamphetamine Hydrochloride,
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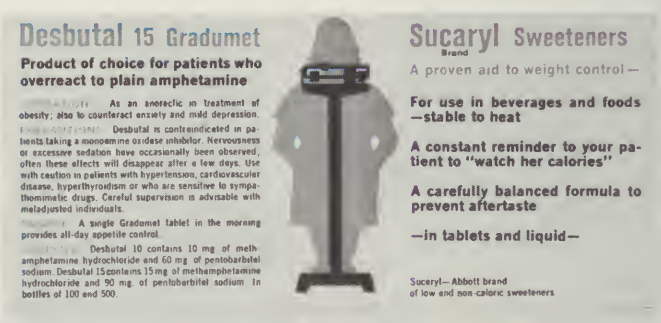


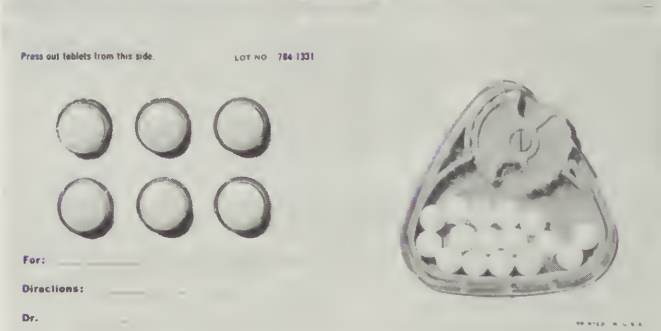
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ANNE ARUNDEL COUNTY

The Anne Arundel County Medical Society held its recent meetings at the Coachman Inn on Ritchie Highway. The past two meetings had been well attended, and interesting programs have been presented.

The following officers and committees have been appointed for the ensuing year: **H. Logan Holtgrewe, MD,** president; **J. Fred Hawkins, MD,** vice president; **Hilary O'Herlihy, MD,** secretary; **Raymond P. Srsic, MD,** treasurer. Elected to the Board of Directors: **Drs. O'Herlihy** (1966), **Leipold** (1966), **Perry** (1966), **Manuzak** (1966-67), **Ray Smith** (1966-67), and **William Williams** (1966-67).

Delegates to the Medical and Chirurgical Faculty are **Charles McDonald, MD** (1966), **Merton Waite, MD** (1966-67), and **Clayton Norton, MD** (1966-68). Their respective alternates are **George Settle, MD, Hubert Manuzak, MD,** and **Aris Allen, MD.** Representative on the Faculty's Policy and Planning Committee is **William Williams, MD,** and his alternate is **Julius Loebl, MD.**

At the January meeting, Mr. I. Robinson of the Social Security Administration in Baltimore spoke on the Medicare program. A long discussion followed. A number of questions were asked and discussed. It was an interesting and productive meeting.

In February the Executive Committee met and took care of its routine business. The March meeting was also held at the Coachman Inn. It was well attended. At this meeting Mr. Denwood Kelly, executive director of the Maryland Blue Shield, spoke on the proposed new prevailing fees program. At the conclusion of his excellent presentation the numerous questions stimulated a lively discussion.

The Executive Committee at its April meeting, discussed the prevailing fee schedule and blood banking. Plans for the annual banquet in June were brought up to date by the program chairman.

Samuel Borssuck, MD

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BALTIMORE CITY

At the April meeting of the Baltimore City Medical Society, a plaque was presented to **Herman Seidel, MD,** for his 54 years of exemplary service to the citizens of Baltimore City. A beautifully worded and heartfelt introduction was given by **Louis V. Blum, MD,** and a standing ovation was tendered Dr. Seidel as **Dr. Siwinski** presented the plaque.

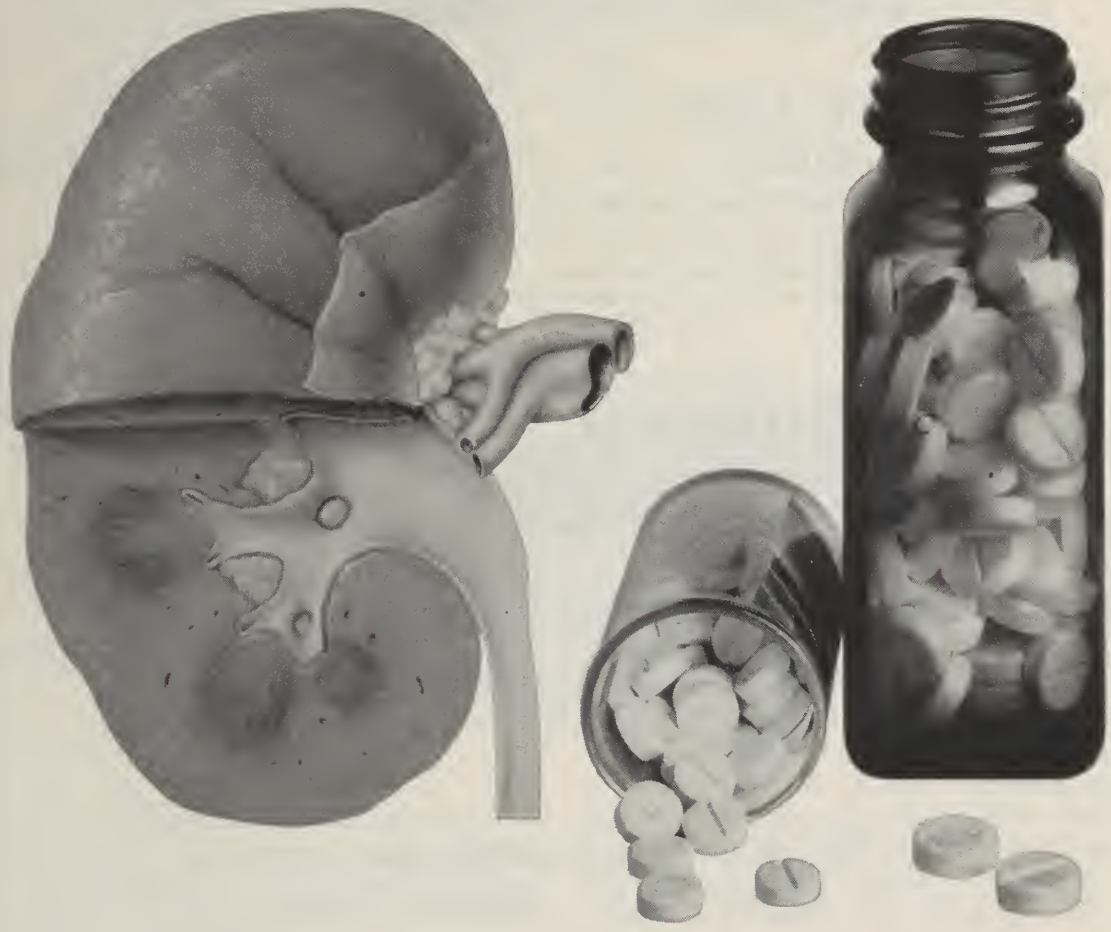
A moment of silence was observed in memory of the following deceased members: **T. Nelson Carey, Nathan J. Davidov, Albert E. Goldstein, J. Mason Hundley, Mitchell S. Kunkowski, Milton Levin, Mason F. Lord, Irwin O. Ridgely,** and **William M. Rowland.**

The following applicants were elected to active membership: **Mary Ellen Avery, Martin J. Birnbaum, Richard Kalinowski, Paul A. Leap, Seymour Perlin, Richard L. Riley, Mary Shams Roberts, Melito M. Torres,** and **Joseph J. Wityk;** by transfer: **Jerrie Cherry, Robert A. Gaertner, John E. Gessner, Ferdinand G. Mainolfi, Morton M. Mower, Lawrence J. Pazourek, Carl B. Schleifer, Martin M. Schuster,** and **Donald A. Wolfel.**

The following were elected to associate membership: **Werner Beck, J. David Bohorquez, Banjamin A. deGuzman, Albert Folgueras, Young Choon Hong, Robert M. Ollodart, Rene Trujillo-Lopez;** by transfer: **Alberto J. Diaz.**

The resolutions coming before the House of Delegates at the coming annual meeting were reviewed. The Baltimore City Medical Society went on record as supporting resolution 1A/66, separating professional fees from hospital charges. The Society went on record as ap-

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understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

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proving in principle Resolution 2A/66, requesting legislation for the creation of maintenance of the school of medical technology, but it opposed the method outlined in the resolution.

Dr. Middleton reported on the meeting on medical ethics of the American Medical Association, held recently in Chicago. **Dr. Morrison** moved that the President give a written report on the activities of the Executive Committee from time to time to the whole membership. The motion was carried. **Dr. Vash** moved that the Society have six monthly meetings from April to October to discuss pertinent current medical social and economic problems and welfare activities. The motion was carried.

Dr. De Hoff spoke regarding the Baltimore City Health Department's plan for the implementation of Title XIX of the Medicare Act. He pointed out that in the inner city there will be 200,000 citizens to be provided care under this provision after July, 1966. He called for interest and concern and active support of the Baltimore City Medical Society both in planning and implementing such plans for the care of these citizens.

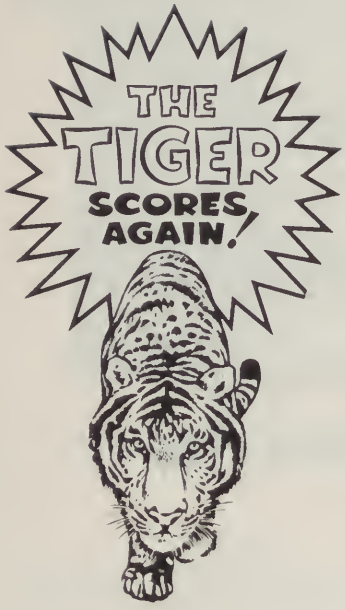
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At its April 12 meeting, the Executive Committee considered suggestions of possible donors for blood transfusions. The suggestions were contained in a report from the Maryland Society of Pathologists, prepared by its president, **Robert G. Lancaster, MD.**

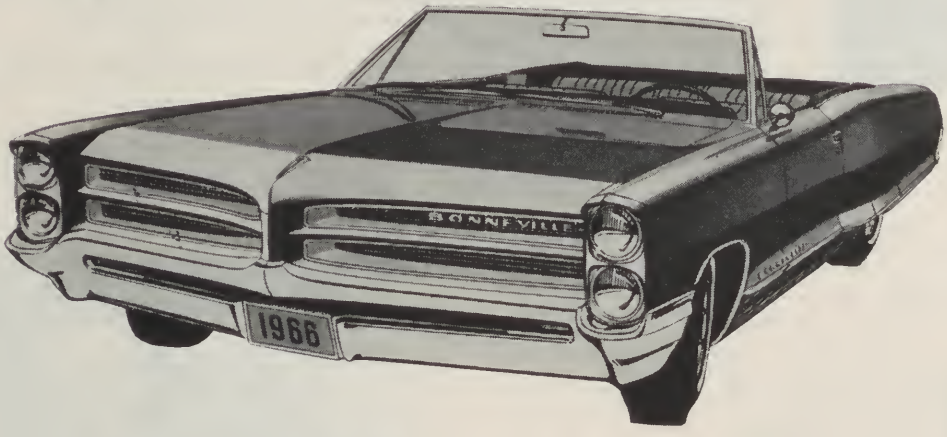
A report was received from **Victor A. McKusick, MD,** of The Johns Hopkins University, advising that a study would be made of children in junior and senior high schools in the city to screen for sickle cell trait and other hemoglobinopathies.

The Committee accepted a proposal from Lederle Laboratories to distribute to Baltimore physicians a suggested form urging patients to obtain a single booster dose of oral polio vaccine.

The matter of summer meetings was con-



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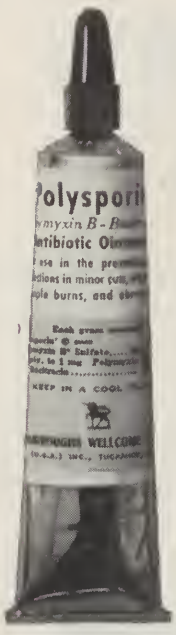
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sidered. President **Arthur Siwinski, MD,** will write a personal letter to the membership concerning this.

John Collins Harvey, MD

WASHINGTON COUNTY

On Saturday afternoon, April 2, the Washington County Medical Society and the Washington County Board of Education cosponsored a sports injuries seminar on the high school and collegiate level. In addition to a panel of local physicians, **Ernest B. Carpenter, MD,** of Richmond, **Duke Dwyer,** trainer at the University of Maryland, and **Lou Sabin,** head football coach at the University of Maryland, presented the program.

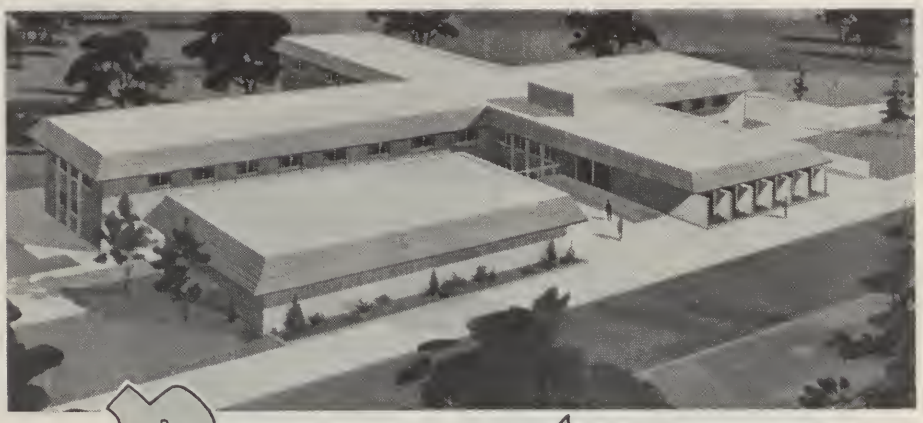
James W. Banks, MD, chairman of the seminar announced that 91 people registered, with 46 from Washington County and 45 from nearby counties in Maryland and adjacent states.

* * * * *

Archie R. Cohen, MD, and **Mrs. Cohen** were



Washington County's doctor and wife of the year, Dr. and Mrs. Archie R. Cohen.



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named doctor and wife of the year. Both have been extremely active in a rural practice of medicine as well as in local and state positions in medicine and paramedical fields.

Doctor's Day was celebrated by a dinner honoring the doctor and wife of the year. A stage show, "Hats Off to Doctors," was the feature event of the Woman's Auxiliary Dinner.

* * * * *

Max E. Byrkit, MD, and **David J. Boyer, MD,** have recently joined the American Academy of General Practitioners.

George Milic, MD, pathologist, and **William M. Slasman, Jr., MD,** otolaryngologist, recently transferred from the Baltimore City Medical Society and are welcomed as new members.

Ronald E. Keyser, MD, chairman of the Poison Control Committee, informed the local citizenry of problems of home poisons through the local newspapers.

John D. Wilson, MD, was recently appointed chairman of the Health & Safety Committee for the Washington County Boy Scout district.

John W. Clark, MD, DDS

WICOMICO COUNTY

Manning W. Alden, MD, chairman of the Faculty's Public Relations Committee, was special guest at the Wicomico County Medical Society's fifth annual press dinner, held in Salisbury on April 18.

Representatives of local news media were informally entertained by the society. Members of the Executive and Public Relations Committees acted as hosts. The purpose was to provide an evening of social relaxation as an expression of appreciation to the press for its cooperation and assistance.

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Representing the press this year were: **Richard Moore,** editor, and **William Cochran,** city editor of the *Daily Times;* **Norman Glenn,** manager, WJDY; **Sam** and **Vera Sherwell,** publisher and editor of the *Salisbury Advertiser;* **William Phillips,** manager, and **B. C. Hargreaves,** commercial manager, WJDY.

Attending for the medical society were **Charles Bagley III, MD,** president; **Marcus Stephanides, MD,** president-elect; **Robert L. Dickey, MD,** secretary-treasurer; **Andrew C. Mitchell, MD,** immediate past president; **James Clifford, MD,** radio chairman; **Stedman W. Smith, MD,** chairman, Board of Censors; **Ollie H. Thompson, MD,** Speakers Bureau chairman; and **Kit Hargreaves,** executive secretary.

Guest speaker at the April meeting of the Wicomico County Medical Society was **John Pompelli,** legislative representative of the AMA, who reviewed legislation of medical interest before Congress.

William Van de Graaff, MD, was voted active membership, and **Aubrey Smoot, MD,** was accepted by transfer from the Sussex County (Del) Medical Society.

Other business included approval of a contribution to help underwrite the expenses of a special meeting of the Wicomico Chapter of the Maryland Conference of Social Welfare. The topic of the meeting was "The Unwanted Child."

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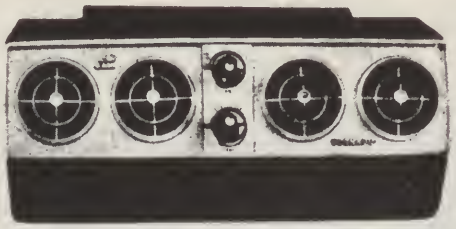
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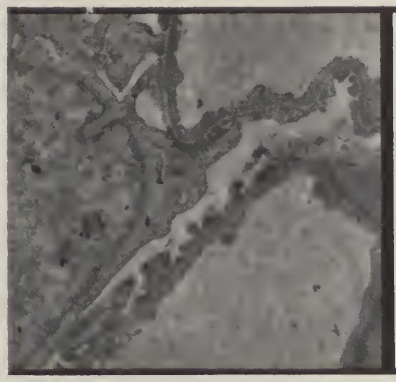
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Ethical and Legal Aspects of Clinical Pathology Laboratories

PAUL F. GUERIN, MD

For many years, laboratories outside of the City of Baltimore have been required to "register" with the State Health Department. In 1965, the Baltimore City exception to this state law was deleted, by agreement with the City and State Health Departments. At the same time, the City Health Department laboratory became a branch of the state laboratory system. This meant that all laboratories throughout the state were required to meet the same standards.

During the 1966 session of the General Assembly, a joint resolution (which does not have the effect of law) was introduced and adopted, calling for a study of the "possibilities for licensing and regulating private medical laboratories in the state." The reasons given for the need of such a study were, among others, that most states have such licensing regulations, the increasing dependence of the medical profession on laboratory work, and reference to an article appearing in the October, 1965, *Reader's Digest,* called, "The Achilles Heel of the Medical Profession." This article was condensed from one appearing in *Redbook.*

In addition, two legislative bills were introduced. House Bill 675 was a State Department of Health bill and would establish by law that the State Health Department *shall* establish such minimum standards and qualifications for any laboratories in the state, *as it may consider necessary.* It also provided for periodic inspections and issuance of permits to such laboratories (italics ours).

Also introduced was House Bill 747 at the request of a newly-formed Maryland Association of Bioanalysts. It provided for a licensing board for "certain clinical chemistry or bioanalytical laboratories" and gave broad powers to this board. The composition of the board was to be: two members of the aforementioned association, one member nominated by the Medical and Chirurgical Faculty of Maryland, one from the American Chemical Society, and one from the State Board of Health. Requirements were established for the titles of laboratory director, laboratory bioanalyst, laboratory technician, and laboratory assistant. Each would have been required to take an examination, except that existing persons, depending on their experience, would have been issued a license upon payment of a fee, depending upon the category of the individual. The State Department of Health would have been charged with enforcement under this bill. Of special interest in this proposal was the failure to provide a category under which a physician might be a laboratory director. This bill died in committee, which means that it was not discussed at any length and no specific action on it was taken.

House Bill 675 was amended in both the House and the Senate. In its final form it provided that:

(1) If a laboratory director has been a director for at least seven years before June 1, 1966, he shall not be required to show further qualification.

(2) Any laboratory that has been operating for seven years or more will be issued a permit and will thereafter be required to comply with rules and regulations established by the State Health Department.

(3) A laboratory will not be required to have a physician director.

(4) No person, partnership, or corporation shall represent or service or maintain in this state any office, representative, or other facilities for the representation or servicing of any laboratories situated in this state or any other state which make examinations in connection with the diagnosis and control of human diseases, unless the laboratory so represented or serviced shall meet or exceed the minimum standards promulgated by the State Board of Health and Mental Hygiene under and pursuant to this section.

(5) No persons, partnership, association, or corporation shall within this state, either directly or indirectly, advertise or solicit business for any laboratory which makes examinations in connection with the diagnosis and control of human diseases if this laboratory is situated in this state or any other state.

The passage of this legislation will bring about several changes in medical practice which are desirable.

(1) Advertising, solicitation of work, and competition based on fees will no longer be legal.

(2) Out-of-state laboratories will not be permitted to solicit work by sending detail men or advertising material to the medical profession in Maryland generally.

(3) Laboratories out of Maryland performing work on Maryland patients will be required to meet the minimum standards required by the State Department of Health.

(4) All clinical laboratories not existing in clinicians offices for their patients will be required to meet minimum standards established by the State Department of Health.

The passage of this legislation will not affect the ethical principles in the conduct of clinical laboratories that have been previously established by the Medical and Chirurgical Faculty. The important provisions of these principles are as follows:

It shall be considered unethical:

(1) For a lay employee, directly or indirectly, to solicit work from physicians

(2) To advertise laboratory services in any media such as magazines, journals, newspapers, etc.

(3) To display any advertising material on vehicles

(4) To distribute mailing containers except on request

(5) To submit specimens to any laboratories not owned (except in licensed hospitals and governmental facilities), operated, and professionally adequately supervised by a licensed and registered physician

(6) To bill for laboratory services not performed by him or his regularly supervised employed assistants

(7) To send specimens to any laboratory rendering laboratory services at a flat fee (so-called contractual agreements)

(8) To share income from laboratory services directly or indirectly with any lay person

(9) To offer laboratory services under a fictitious name

(10) To offer laboratory services for the care of patients as a corporate structure

(11) To have a financial interest in any clinical laboratory where the physician is not personally and professionally responsible for the quality of the work performed in the laboratory

(12) To collect fees from any insurance company for laboratory services not performed by him or his regularly employed assistants

On June 17, 1965, the Council of the Medical and Chirurgical Faculty of Maryland adopted a report of the Laboratory Services Subcommittee of the Liaison Committee which stated in part:

> The Subcommittee feels that with the full cooperation of the Medical profession and others concerned, a program can be maintained in Maryland obviating the need for legislation to enforce rules which basically call for ethical conduct.

Unfortunately, this statement of policy has not been followed and additional legislation has been enacted, only some of which is good. In the final analysis, the responsibility for good laboratory work rests with the referring physician. If he will demand accurate and prompt service for his patients on a completely ethical basis, laboratories which offer less cannot survive. Furthermore, if this responsibility is exercised, additional legislative control should not be necessary.

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The Heart Page

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IDIOPATHIC MYOCARDIOPATHY

Part I: Clinical Features

GUSTAV C. VOIGT, MD
Fellow in Medicine

KENNETH B. LEWIS, MD
Chief, Cardiovascular Service, and Assistant Chief of Medicine, Baltimore City Hospitals

Idiopathic myocardiopathy is a nonvascular myocardial disease characterized clinically by heart failure with cardiomegaly and gallop rhythm and pathologically by diffuse patchy fibrosis and nonspecific inflammatory changes. It is a common disease.

Several investigators have found that idiopathic myocardiopathy is a significant cause of heart disease in adults. Harvey[5] found that it was responsible for more than 70% of the nonvascular myocardial disease in a large series of patients.

In the Baltimore area, we observed 40 patients with this disease during the past two years. In this article we will outline the clinical features of idiopathic myocardiopathy. Next month we will discuss the management of patients with this disease.

The cause of idiopathic myocardiopathy is unknown, but several thoughts are prevalent concerning its pathogenesis. A relationship to previous acute viral myocarditis, sometimes remote and often subclinical, has been suspected. Some patients have a history of alcoholism; but many do not, and the etiologic significance of alcohol is not clear. Woodward[9] and others have conducted experiments in animals, from which they infer that hyperimmune mechanisms may be important. Occasionally heart failure of obscure cause occurs in the postpartal period, but the roles of pre-existing myocarditis, hypertension, vascular myocardial disease due to toxemia, and pulmonary embolization are often not well defined in such cases, and it is doubtful that there is a specific myocardiopathy related to the puerperium.

Idiopathic myocardiopathy is more common in men, but the sex ratio is less striking if women who have heart failure of uncertain cause associated with pregnancy are included. Most patients are between 20 and 50 years old, although the disease has been reported in all age groups. The predominance of Negroes seems to reflect, at least in part, the populations studied, for many white patients with this disease are seen at centers which have a more racially-balanced patient population.

Most patients present with heart failure, cardiomegaly, and gallop rhythm. There are no distinctive clinical features, and many manifestations of idiopathic myocardiopathy suggest heart disease due to other causes, such as arteriosclerosis, hypertension, rheumatic fever, and constrictive pericarditis. The insidious onset of congestive heart failure in a patient who does not have

From the Departments of Medicine, The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital and Baltimore City Hospitals.

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Dr. Voigt receives support from a National Institutes of Health Research Fellowship I-F2-HE-28,655-01.

a history of myocardial infarction or angina pectoris, and who does not have a predisposition to coronary artery disease, such as diabetes mellitus or hypercholesterolemia, suggests idiopathic myocardiopathy.

Although chest pain occasionally occurs in patients with idiopathic myocardiopathy, it usually *follows* the onset of heart failure. Patients with heart failure due to arteriosclerosis, on the other hand, most often have a history of angina pectoris or pain due to infarction *before* the appearance of heart failure.

Diastolic hypertension is common in patients with idiopathic myocardiopathy, particularly when heart failure is present, but it is usually associated with a narrow pulse pressure and indicates low cardiac output rather than hypertensive vascular disease. Murmurs of relative mitral or tricuspid insufficiency may occur, suggesting rheumatic heart disease, but these murmurs diminish in intensity or disappear when heart failure responds and cardiac size decreases. Murmurs due to rheumatic valvular disease become louder as the heart becomes compensated and cardiac output increases.

Some patients present with anasarca, hepatomegaly, and striking increase in venous pressure, suggesting cardiac tamponade due to pericardial effusion or constrictive pericarditis. A history of left ventricular failure preceding these signs of right ventricular failure favors myocardial rather than pericardial disease, but this is not absolute. Patients with idiopathic myocardiopathy may present with right ventricular failure. Pericardial scanning, carbon dioxide angiography, or diagnostic pericardiocentesis may be necessary to exclude constrictive pericardial disease with certainty.

The incidence of pulmonary and systemic emboli, the latter from mural thrombus in the left side of the heart, is high. We have seen an occasional patient present with cerebral embolization as the first manifestation of this disease. Arrhythmias, particularly atrial fibrillation and premature ventricular contractions, are frequent. Idiopathic myocardiopathy should be suspected whenever a patient presents with atrial fibrillation of obscure cause.

Laboratory findings are nonspecific. The chest x-ray practically always demonstrates cardiomegaly at some point in the patient's course. In addition to arrhythmias, non-specific ST-T wave changes, left ventricular hypertrophy, and bundle branch block are the most common electrocardiographic abnormalities. Myocardial biopsies reveal no pathognomonic changes, and such material is of little diagnostic or therapeutic value. We feel that myocardial biopsy is still an investigational tool only.

Mortality is high. Death occurs as a result of heart failure or its complications. Sudden and unexpected death is frequent, probably due to arrhythmias or embolization. Postmortem examination reveals cardiac hypertrophy, dilatation, diffuse patchy fibrosis, and nonspecific cellular infiltrates. Mural thrombi in the left and right sides of the heart are often seen, suggesting that at some point in the patient's course, myocardial and endocardial damage occurred, perhaps secondary to inflammation. Other findings are consistent with heart failure, and pulmonary and systemic infarctions may be found.

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EDITOR

Problems of Diagnosis in Chronic Diseases, Part I

DOUGLAS CARROLL, MD
Chief of Physical Medicine and Rehabilitation
Baltimore City Hospitals

In an excellent survey of diseases in the elderly, Wilson, Lawson and Brass[1] were impressed by the multiplicity of diseases contributing to disability. It is apparent that correct diagnosis underlies successful rehabilitation and comprehensive management.

A review of a number of attempts to analyze the causes of diagnostic errors[2-4] shows two major situations associated with misdiagnosis. The first is an inadequate history. This situation arises particularly in elderly people who are living alone and are found comatose or confused. The second situation leading to diagnostic error is uncritical dependence on laboratory work, previous diagnoses, or obsolete physical examinations.

Another approach to improved diagnosis is to find those conditions most frequently missed and to keep these conditions at the forefront of attention in all cases. A number of books have been published[5-7] which are helpful in organizing symptoms and signs into diagnostic categories.

Our interest in the problems of diagnosis in patients with multiple diseases has been directed especially toward diseases which are treatable or curable. Over a number of years, we found that the treatable diseases, syndromes, or situations most likely to be mistaken fell into several groups:

I. Infections
II. Intra-abdominal abscesses, perforations, and gangrene of viscera amenable to surgical correction
III. Hemiplegia
IV. Endocrinopathies

Fevers and Infections

In elderly patients, in patients with chronic diseases, and in patients with lethal disease, particularly cancer, there are three situations in which treatable infections are common yet frequently missed in hospitalized patients.

Tuberculosis.—Tuberculosis is a disease almost universally present yet inactive in elderly people, hovering in the background, ready to flourish and spread if the patient's resistance is reduced by some other disease. In many situations, it is the tuberculosis rather than the initial underlying disease which causes the patient's death. Tuberculosis is to be sought particularly in patients with systemic lupus erythematosis, diabetes mellitus, sarcoid, pulmonic stenosis, chronic alcoholism, after major stomach resections, and in association with steroid treatment.

Hollister[8] found 22 patients with tuberculosis who came to autopsy in an acute hospital whose policy is not to admit patients with known tuberculosis. Fourteen patients had not been diagnosed clinically. Five of these had pulmonary tuberculosis, but the remainder had extrapulmonary tuberculosis making diagnosis difficult. Some reasons for misdiagnosis were lack of appreciation of the frequency of tuberculosis in elderly people, misinterpretation of x-rays, and failure to use all diagnostic aids.

Tuberculosis may present in unusual yet fairly

characteristic ways.[9] It is a frequent cause of unexplained fever.[10, 11] Hematogenous disseminated tuberculosis is the most frequently missed treatable infection in our experience.

Bacterial endocarditis.—Septicemia plays an important role in the pathogenesis of bacterial endocarditis, so that one should be particularly alert for its development with instrumentations of the genitourinary system, in pneumococcal pneumonia, neoplastic, and hematologic diseases.[12] Findings may be atypical in older people.[13]

The presentation of the disease may be in a joint, in the kidneys, brain, or other organs which draw attention away from the heart.

Infections in patients with cancer.—Browder, Huff, and Petersdorf have drawn attention to the occurrence of fever in patients with malignant disease.[14] Of 351 episodes of fever in 343 patients with malignant disease, they noted that infection or obstruction was the cause of the fever in 38%; 16% of the fevers were unrelated to the tumor, and they were able to attribute the fever to the cancer itself in only 5.4% of the cases. It is therefore important not to attribute fever occurring in a patient with malignant disease to the tumor, since the patient's life may be greatly prolonged if an unrelated infection can be identified and treated.

McCabe and Jackson[15] have documented the rapidly increasing incidence of bacteremia associated with other diseases in hospital practice.

Intra-abdominal Abscesses, Perforations and Gangrene

Where treatable conditions of the abdomen were missed, the clinical problem centered around making the decision to perform a laparotomy. Several situations seemed to recur repeatedly in obscuring the necessity for performing a laparotomy. The patient frequently could not give a good history, nor could he describe his abdominal symptoms at the time of examination. The second problem was the presence of another disease distracting attention from the abdomen as the point of immediate importance. A third difficulty was procrastination because the general medical condition of the patient was poor. A fourth difficulty was that many of the elderly patients did not present the usual signs of peritonitis.

One case of liver abscess was overlooked at laparotomy which included a liver biopsy. Another patient was repeatedly examined for suspected peritonitis and had bilateral lower quadrant paracenteses which yielded no pus. The patient was found at autopsy to have a purulent pancreatitis with peritonitis of the lesser omental sac.

One of the most frequent treatable abdominal emergencies repeatedly missed is perforation of an acute or chronic duodenal ulcer with peritonitis and death. Duodenal ulcers have been seen frequently in patients with Laennec's cirrhosis, in patients with cerebrovascular accidents and hemiplegia, in patients with neurological diseases, particularly with diseases of the spinal cord, in patients with respiratory acidosis secondary to pulmonary obstructive disease, and in patients with poliomyelitis requiring artificial ventilation because of respiratory paralysis.

Perforation of a gangrenous vermiform appendix in elderly patients or those with multiple chronic diseases has been common in our experience.[16]

Because of the high incidence of gall stones in elderly men and women, one might expect a high incidence of acute gall bladder disease with obstruction, gangrene and perforation.

An 81-year-old man had a diagnosis of acute cholecystitis made on admission to the hospital. Because of dehydration, septicemia (proteus mirabilis), and anuria, operation was delayed several days for hydration and treatment of infection. He died on the fifth hospital day and was found to have gall stones obstructing the ampulla of Vater, with an abscess of the gall bladder, pylophlebitis, and liver abscesses of several weeks' duration.

Morse and Deterling[17] point out that time spent in evaluating cardiac, pulmonary, and electrolyte conditions even in the most acutely ill elderly patient is well justified before operation. In the present case, it is apparent that emergency operation might have saved the patient's life.

Another rarer type of perforation does not occur within the abdomen but is so frequently associated with or mistaken for abdominal disease that it should be mentioned here. This is perforation of the esophagus often associated with hemorrhage and mediastinitis. Since its cause may be the act of vomiting, it frequently complicated some abdominal disorder.

(TO BE CONTINUED)

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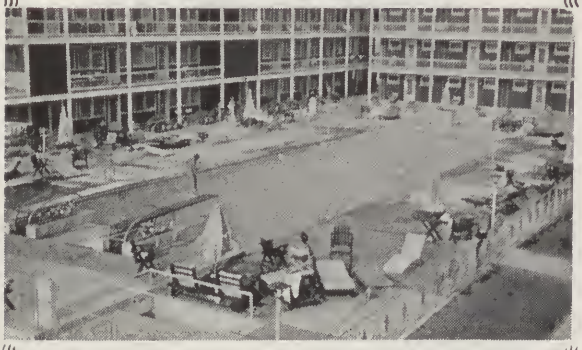
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Management of Acute Alcohol Withdrawal Symptoms

JOSEPH F. CHAMBERS, MD

This report, an approach to the medical withdrawal of the acutely ill alcoholic, is based on experience with some 3,000 alcoholics over the past two years at the District of Columbia General Hospital, a 1,250-bed facility serving a population of almost one million people. The average number of alcoholics admitted is 1,500 per year, constituting over one-third of all admissions to the Department of Psychiatry.

The Alcoholic Unit, a 35-bed ward in the Department of Psychiatry, is sufficiently identified as a separate area to avoid the alcoholic's reluctance to associate his problem with anything "mental." Acceptance of the prob'em initially as having anything to do with a neurosis is impossible for most alcoholics because such a concept adds to their already unbearable feelings of inadequacy and inferiority. But in a group with the same illness the patient can identify and socialize with other alcoholics, relieving the feeling he has of being different, cast out, and alone.

The primary function of the Alcoholic Unit is the medical management of withdrawal symptoms of large numbers of alcohol addicts coming from several sources but chiefly from the Emergency Room at D. C. General Hospital. Patients are seen by the resident physician in Psychiatry and are admitted specifically because of the severity of their withdrawal symptoms. Grave medical and surgical problems are not admitted to Psychiatry, being treated in the medical and surgical divisions. However, medical problems are routinely admitted when the chief complaint is alcohol withdrawal. These Emergency Room admissions are sick patients, over half of them in or impending delirium tremens. Others have had convulsions prior to admission or have histories of seizures. Most of them have had previous, some repeated, admissions.

While chronic alcohol intoxication also results in change in the social, behavioral, and familial areas, for the physician the presenting changes are metabolic and clinical. Calorie wise, alcohol is a fuel, nothing more; it is void of vitamins, proteins, and minerals. When, as in the alcoholic, ethanol becomes a major source of fuel, protein, vitamin, and mineral deficiencies begin to appear. Since alcohol is also a diuretic, the alcoholic becomes dehydrated. Clinically, he is restless, tense, agitated, often depressed, guilty, and anxious. He demands symptomatic relief and obtains it with

more alcohol. Abrupt cessation of drinking in the alcoholic results in the development of a series of progressive symptoms whose severity is roughly proportional to the length and amount of drinking preceding withdrawal. Pharmacologically, ethyl alcohol is a central nervous system (CNS) depressant. The prolonged excessive use of this drug results in adaptive cellular metabolic changes seen clinically as withdrawal symptoms.

The patient shows signs of CNS involvement by agitation, confusion, and tremulousness. He may be dizzy and ataxic. Further addiction is seen in the development of delirium, hallucinations, and even convulsions. The ever-present possibility of head injury in the acute alcoholic must be remembered; head injury may be masked by the withdrawal.

The cardiovascular system shows tachycardia, premature ventricular contractions, and other arrhythmias. There is substantial systolic and moderate diastolic hypertension. The patient has hemoconcentration from his dehydration. Leukocytosis and variable fever are usually present.

Gastrointestinal symptoms are prominent, varying from anorexia and mild malaise to nausea, vomiting, and diarrhea. The patient may have modest hepatic congestion or be moribund with florid cirrhosis, ascites, and jaundice.

The shaking alcoholic who is in or impending on delirium tremens is anxious, frightened, terrified, often beyond our comprehension. These patients can be suicidal. They often convulse and behave in a bizarre psychotic fashion. At this point, and well before it, they are valid medical and psychiatric emergencies.

The medical treatment of acute alcohol withdrawal is directed primarily to the correction of the disturbed physiology. This involves sedation, correction of fluid balance, and vitamin, mineral, and protein replacement.

Drug Therapy

The use of tranquilizing drugs has brought about a vast change in treatment. Chlordiazepoxide hydrochloride (Librium), currently the drug of choice, produces greater muscular relaxation than other agents, less drowsiness, and less hypotension.[1] A recently recognized and important property of the drug is its anticonvulsant effect. This is of particular importance in the treatment of alcoholics where withdrawal convulsions are a grave and occasionally fatal complication. The effect of chlordiazepoxide on the blood pressure seems to be cumulative after large doses. There is no sudden initial reaction; this is an advantage over the phenothiazines. (Our experience at D. C. General Hospital with chlordiazepoxide,[2] chlorpromazine, and trifluoperazine[3-5] have been published elsewhere).

The agitated alcoholic is treated as soon as he is seen. Many factors influence initial drug dosage: agitation, tremulosity, delirium, convulsions, age, muscle mass, the presence of intoxication, and the degree of dehydration and fever.

Chlordiazepoxide is given 50 to 200mg intramuscularly on admission. This is repeated one to six times in the first 36 hours depending upon the degree of agitation and delirium. Significant relief of even the severe cases occurs within 36 hours. High dosages are continued until this substantial relief takes place. At this point, medication is sharply decreased and changed to the oral route: 25 to 50mg three times a day for two to four days. The patient is drug-free one to two days prior to discharge.

Chloral hydrate, 1.0 to 1.5Gm, is used for bedtime sedation, and with chlordiazepoxide, usually provides restful sleep from which the patient is readily aroused. We no longer use barbiturates for bedtime sedation; as sedatives for alcoholics they are effective, yet frequently produce intoxication instead of hypnosis, and are also lethal drugs with addiction liabilities.[6] We do not use paraldehyde: its odor is offensive, its margin of safety inferior, and its addictive properties widely known.

Grand mal seizures seen in alcohol withdrawal states have been aptly called "alcolepsy." Formerly diphenylhydantoin and phenobarbital were routinely given to all patients with a history or an actual episode of convulsions; but since the advent of chlordiazepoxide, withdrawal seizures are rare at D. C. General Hospital. Diphenylhydantoin is still used, prior to and after discharge where there has been an actual seizure, and phenobarbital in the acute convulsive crisis to insure control.

Fluid, Food, Rest

Correction of the fluid imbalance has not been found to be a problem in the large majority of cases. With tranquilizers, it is quite possible to hydrate orally. Fluids are available and encouraged, and are forced on the sicker patients. Less than 10% have been found to require intravenous

fluid therapy. The patient is given an ample nourishing diet, with milk and fruit juices between meals, and rests for two hours after the noon meal and for nine hours at night. The alcoholic in the throes of a drinking bout does not eat nor does he really rest; the sleep he catches is fitful and of short duration, and the importance of rest and food in his recovery has long been recognized.

Vitamin replacement therapy is accomplished by either oral (multivitamin capsules) or parenteral administration. With the sicker alcoholic, where there is evidence of weight loss, cirrhosis, and delirium tremens, intramuscular B-complex and C vitamins are given daily until discharge. Antispasmodics are used frequently. Chlordiazepoxide seems to have an autonomic quieting effect by itself in most cases. Others require anticholinergics and gels to obtain relief from the discomfort caused by gastritis and low-grade peptic ulcers.

A major advantage of hospital treatment of the alcoholic lies in the substantial advances in nursing skills. Good clinical judgment by experienced and interested personnel is vital, since signs pointing to impending convulsions or relapse into delirium tremens can be recognized if they are known and looked for knowledgeably.

In some toxic long-term alcoholics, the acute brain syndrome does not clear in three to four days. They pass from the acute, agitated, delirious stage to an intermediate period of confusion and disorientation marked by severe memory loss. These patients rapidly show signs of sedation with medication. Treatment here involves reduction or discontinuance of medication. Only that necessary to control agitation and insure sleep is used. Fluids, parenteral vitamins, and vigorous nursing care generally resolve this intermediate phase within 10 to 20 days. These patients are peculiarly prone to bronchopneumonia and may have some liver damage, but will do surprisingly well with good nursing care and close medical supervision. Many recover rapidly; for others, complete recovery may take many months; some do not improve at all, remaining confused and disoriented with permanent organic damage. These unimproved patients are committed to St. Elizabeth's, the Federal Mental Hospital for the District of Columbia.

Therapy in the Home

Treatment of acute alcoholic withdrawal outside the hospital involves several problems not encountered in the controlled hospital setting. Intoxication, family strife, abuse of medication—one or all may confuse the treatment picture.

However, alcohol withdrawal often can be managed in the home. In many localities it has to be handled there, since general hospitals refuse to admit on this diagnosis alone. This refusal stems partly from the mistaken idea that alcoholics are unmanageable. The Alcohol Unit at D. C. General Hospital is the quietest, cleanest unit in Psychiatry. With an average census of 30 patients, not more than two are in restraints at any one time, and these two are usually quiet. The fairly sober, sick alcoholic who wants to get well is an eminently manageable patient.

Treatment in the home is quite possible provided certain ground rules are followed. Patients, when seen, should be sober or nearly so, and they must be interested in treatment. (It is pointless to make a housecall at the family's request on a still drinking alcoholic who has a case of whiskey and is maudlin-drunk). The patient should be willing to attempt to follow a prescribed course of treatment. If at all possible, an interested family member should be the nurse, supervising the patient, giving him his medication, encouraging and providing fluids and later food.

Often, after the first day or two of treatment, someone from the local Alcoholics Anonymous (AA) group may help out here. However, AA is interested only if the patient is interested. It behooves the physician treating alcoholics to have some understanding of AA and to have contacts with these fine people.

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Maternal Welfare

Instructive case histories submitted by Subcommittee on Maternal Welfare

JOHN WHITRIDGE, JR., MD, chairman

Case 13—Rupture of Uterus

The patient was 41 years old, para 7, with seven living children. All of her previous pregnancies had been essentially uncomplicated. The birth weight of the infants ranged from 6 lb 1 oz to 7 lb 14 oz. Her prenatal course in the present pregnancy had been uncomplicated. She had made six prenatal visits. Total weight gain had been 23 pounds, and the blood pressure had remained normal. The latest hemoglobin reported during pregnancy was 11.8gm.

On August 15, the patient went into labor spontaneously and was admitted to the hospital at 8:30 PM. Admission physical examination revealed the cervix 3cm dilated, with the vertex presenting and membranes intact. Contractions were occurring every 15-20 minutes, lasting approximately 30 seconds.

Three hours after admission, at 11:30 PM, contractions had diminished in frequency and intensity, and an intravenous pitocin drip with 5 units of pitocin in 1000cc of 5% glucose was begun. After four hours of pitocin stimulation, the cervix was fully dilated, and shortly thereafter the presening part was visible. Ethylene anesthesia was given, and a full-term living girl weighing 6 lb 12 oz was delivered spontaneously at 4 AM. Two minutes afterward, the placenta was expressed by the Crede method. One ampoule each of intravenous pitocin and intramuscular ergonovine was given immediately after delivery of the placenta.

Shortly thereafter it was noted that the patient was bleeding rather freely. Anesthesia was resumed, and the vagina and cervix were examined for lacerations and the uterine cavity was explored. No lacerations were found, nor were fragments of placental tissue discovered. Blood was sent to the laboratory for typing and cross-matching. A pitocin drip was reinstituted, and the excessive bleeding subsided. The patient was in mild shock, blood pressure not stated, and a plasma expander was begun until whole blood arrived. At 4:50, the administration of 1000cc whole blood was begun, and the patient's blood pressure rose to normal. Three hours later she was returned to her room.

At 10:15 AM, the uterus was found to be relaxed and boggy, and about 200cc of blood was expressed from the uterus and vagina. Blood pressure was recorded as being 60/0. An additional two units of whole blood were begun, together with vasopressers and pitocin, with little change in the patient's condition. Two more units of whole blood were administered, making a total of 3000cc. In spite of this, the patient remained in shock and was pronounced dead at 3:50 PM, August 16, approximately 12 hours postpartum.

Postmortem examination revealed an incomplete rupture of the uterus, 3cm in length, in the left lateral wall of the lower uterine segment, with extravasation of blood into the left broad ligament. There was no free blood found in the peritoneal cavity.

Comment

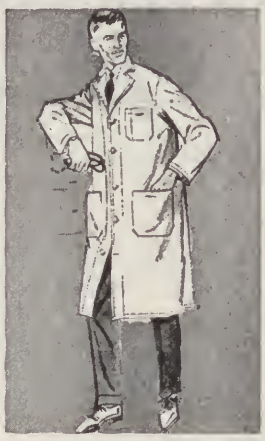
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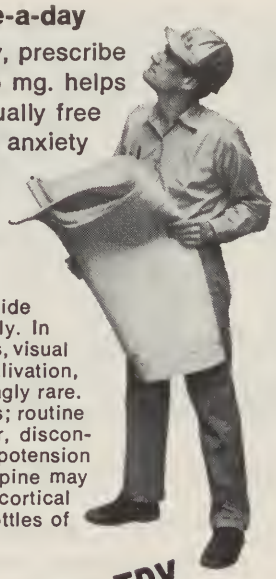
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cism concerned the use of pitocin stimulation in a para 7. It is generally agreed that pitocin stimulation in patients of high parity is unduly hazardous and should be avoided.

A second preventable factor was the failure to detect the laceration in the wall of the uterus. Had a more careful examination been carried out and the rupture diagnosed, prompt hysterectomy probably would have altered the outcome.

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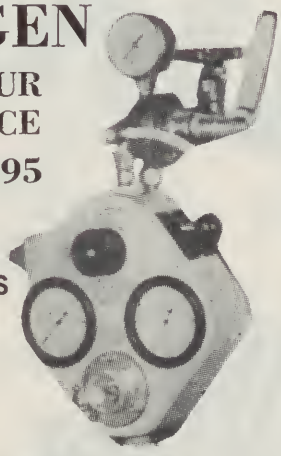
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Diagnosis and Treatment of Streptococcal Pharyngitis

KARL H. WEAVER, MD

Approximately 1-3% of persons who have an untreated type A, beta hemolytic streptococcal infection (hereafter referred to as *streptococcal infection*) will develop acute rheumatic fever. This initial attack of acute rheumatic fever can be prevented if the streptococcal infection is accurately diagnosed and adequately treated. The highest incidence of rheumatic fever is between the ages of about 5-16 years with the peak at about 8-10 years. It is the physician who cares for children who has the best opportunity to prevent this potentially crippling and disabling and even fatal disease.

The typical signs and symptoms of streptococcal pharyngitis are sudden onset of fever and sore throat. The child appears ill and has tender cervical adenopathy. The pharynx and tonsils have a beefy red injection, and usually an exudate is present. Unfortunately, many persons who have streptococcal pharyngitis do not exhibit these signs and symptoms; some who do may have a pharyngitis of viral etiology. Coxsackie or an adenovirus pharyngitis may be manifest by an exudate. Using clinical criteria alone, streptococcal pharyngitis can be diagnosed accurately in only 50-70% of cases.

Laboratory aids, notably throat culture, are most important. Only by using this simple and inexpensive technique can streptococcal pharyngitis be identified accurately, allowing proper treatment to be instituted and rheumatic fever prevented. This technique of throat culture, plating and incubation of the culture, and recognition of beta hemolytic streptococcal colonies are well described in a publication of the American Heart Association entitled *A Method for Culturing Beta Hemolytic Streptococci From the Throat.* This concise pamphlet can be obtained from your local Heart Association chapter. It is imperative that any suspected streptococcal pharyngitis be confirmed by culture. The technique should become a routine office procedure.

Once a diagnosis of a streptococcal infection has been made, treatment must be adequate to prevent rheumatic fever. Whatever antibiotic is used, it must be given for a full 10 days. Penicillin is clearly the drug of choice, and erythromycin second. Tetracyclines are unreliable because of resistant streptococcal strains. Sulfonamide preparations have no value in the treatment of streptococcal infections.

It is important for therapy to be continued for 10 days even though clinical improvement may occur in a much shorter time. Intramuscular penicillin is probably the best form of therapy, since it prevents the patient from discontinuing the antibiotic after several days (which frequently happens with oral therapy) because of the relief from symptoms. A single injection of 1.2 million units of benzathine penicillin (600,000-900,000 units in a child) is adequate. This preparation may cause a somewhat painful local reaction. Also, 600,000 units of penicillin in oil

From the Department of Pediatrics, University of Maryland School of Medicine.

with aluminum monostearate intramuscularly every third day for three doses is adequate. It is impractical to use aqueous penicillin. A single dose of procaine penicillin is inadequate.

If oral penicillin is used, a total daily dose of 800,000 to 1.2 million units divided into four doses should be given. If potassium penicillin G is used, it should be given on an empty stomach to allow maximal absorption.

For those patients who are sensitive to penicillin, erythromycin is the drug of choice. It should be given in the dosage of 125-250mg four times a day for 10 days. Tetracyclines should not be used unless it is known that the infecting organism is sensitive to that antibiotic.

In summary, rheumatic fever is a preventable sequela if the preceding streptococcal infection is accurately diagnosed and adequately treated. Throat culture is vital to accurate diagnosis. Adequate treatment consists of an adequate blood level of the appropriate antibiotic (penicillin clearly being the drug of choice) for a full 10 days.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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DEPARTMENT OF HEALTH

STATE OF MARYLAND

William J. Peeples, MD, MPH, *Commissioner*

Highlights

MEDICARE CERTIFICATION

Under Title XVIII, the Department is charged with ascertaining which hospitals, nursing homes, home health agencies, and independent laboratories meet the conditions of participation in the Medicare program and with making recommendations to the Social Security Administration. Participation of hospitals, home health agencies, and independent laboratories begins on July 1. For extended care facilities, participation begins on January 1, 1967.

The Bureau of Medical Services has been working intensively with general, chronic disease, mental, and tuberculosis hospitals to get as many as possible recommended for certification by May 31, the deadline set by the Social Security Administration for participation by July 1. The major problems are in ascertaining that the 19 institutions not accredited by the Joint Commission on Accreditation of Hospitals take steps to substantially meet the conditions for participation. Each hospital must have a utilization review plan functioning by July 1. The operation of the plan is a responsibility of the medical profession and must have the approval of the medical staff as well as that of the governing body of the hospital.

Home health agencies, which initially will be limited mainly to local health departments, are now being urged to apply for participation and take actions necessary to qualify for certification.

The Bureau of Laboratories is working with independent laboratories to help them gain certification.

Work on extended care facilities is in the initial stages, which will be intensified after the peak load of work on other providers of service is accomplished.

PESTICIDES IN FOODS

The laboratory determination of pesticide residues in foods is complex because of the variety of food products and the number of substances and minute quantities of residue that may be involved. During 1965, the Bureau of Laboratories examined 425 samples of milk and 174 samples of other foods. When elevated quantities were found in milk, the production of the dairy involved was placed under closer surveillance and, in some instances, excluded from market. In the vegetables—lettuce, cabbage, endive, tomatoes, broccoli, and other greens—the quantities found were below tolerance levels. No significant levels were found in samples of oysters, clams, hamburgers, or hot dogs. The group of pesticides detected in any amounts was the chlorinated hydrocarbons (DDT, Aldrin, etc.); none of the organophosphates (Malathion, etc.) was detected, possibly because of lack of specific equipment. The continuance of the surveillance program is of significance in the accumulation of detailed knowledge of our chemical environment and provides a guide to the development of laboratory capabilities.

INTERAGENCY CONFERENCE ON SCHOOL HEALTH PROBLEMS

Representatives from 17 local health departments and departments of education attended the Maryland Conference on Critical School Health Problems: Smoking and Drug Addiction, sponsored jointly by the Maryland State Departments of Education and Health, in cooperation with

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The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

The acceptance: The majority of the 142 patients studied expressed a definite liking for the products. *There were only two refusals.* An independent taste-test with 50 healthy children further substantiated the excellent acceptability of the orange-flavored forms.

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Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

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the state Cancer Society, the Heart Association, the Tuberculosis Association, and PTA. The all-day conference was attended by representatives from the Department of Catholic Education and the teacher-training institutions of the state.

At the conference, the Maryland Committee on Smoking and Health distributed copies of the resource unit on Smoking and Health for Grades 7 through 9. This unit is the second of a series of teaching aids developed by the Committee to assist in teaching the adverse effects of cigarette smoking on health. The first aid, for Grades 5 and 6, was developed last year and has been widely distributed throughout the state.

NUTRITION IN MATERNITY PROGRAMS

A conference on nutrition in maternity programs brought 30 persons from state and local health departments to the central office to discuss ways to provide the best use of nutrition services in maternity programs. Guidelines were formulated to help the nutritionist function more effectively as a part of the health team serving the maternity patient.

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BOARD OF MEDICAL EXAMINERS OF MARYLAND

Addenda to Directory of Registered Physicians

PHYSICIANS REGISTERED FEBRUARY 1, 1966, TO MAY 1, 1966

Bell, Joseph Asbury, 9318 Elmhurst Drive, Bethesda, Md. 20014

Boyd, DeWitte Talmadge, 3 Monmouth Rd., Baltimore, Md. 21228

Boyle, Charles Dennis, 4107 Oliver St., Chevy Chase, Md. 20015

Brown, William Virgil, 550 North Broadway, Baltimore, Md. 21205

Charache, Patricia, 5701 Chilham Rd., Baltimore, Md. 21209

Charache, Samuel, 5701 Chilham Rd., Baltimore, Md. 21209

Child, Edwin Lee, 5503 Darel Dr., Apt. 102, Suitland, Md. 20023

Clark, Ranville Stopford, 4811 North Capitol St., NE, Washington, D.C.

Cohen, Gordon Richard, 2205 Forest Glen Rd., Silver Spring, Md.

Fahrney, Peter Martin, RD#5, Frederick, Md.

Fitzgerald, Robert Brassill, 1205 Autre Court, Rockville, Md. 20851

Flinn, Robert Barr, 1107 Nottingham Rd., Wilmington, Del.

Gardner, Allen Stiles, 1807 Eldon Lane, Silver Spring, Md.

Hambrick, George Walter, Jr., 3400 Spruce Street, Philadelphia, Pa. 19104

Hecht, Robert Harold, 6010 East Pratt Street, Baltimore, Md. 21201

Herrmann, Raymond William, 21 Thornhill Rd., Lutherville, Md. 21093

Jacobs, Eugene Robert, 1307 Kingston Ave., Alexandria, Va. 22302

Johnson, Lewis William, Jr., Quarters S-9, U. S. Naval Station, Annapolis, Md.

Johnson, Thomas Russell, 504 S. 2nd St., LeSueur, Minn.

Katz, Ernest Barney, 9801 Portola Drive, Beverly Hills, Calif. 90210

Kessler, Irving Isar, 450 Clarkson Ave., Downstate Medical Center, Brooklyn, N. Y.

Kramer, Frederick H., Eastern Shore State Hospital, Cambridge, Md. 21613

Kredich, Deborah Welt, 5910 Rolston Rd., Bethesda, Md. 20034

Kwaterski, Mitchell Francis, 3A Sellers Rd., Annapolis, Md. 21402

Mandeville, Frederick Byrne, 10 Westham Parkway, Richmond 29, Virginia

Mehring, Samuel Stuart, 312 Beverly Hills Drive, Youngstown, Ohio 44505

Miller, Lawrence Percy, 301 East Main, Sharpsburg, Md.

Morris, David Lawrence, 8601 22nd Ave., Adelphi, Md. 20783

Morse, Peter Hodges, U. S. Naval Weapons Station Disp., Charleston, S. C. 29408

Mullen, John Conlin, 4605 Dabney Drive, Rockville, Md. 20853

Nelson, Ralph Gilbert, 5719 Beech Ave., Bethesda, Md.

Pagan-Lugo, Jose Angel, 807 Braddock Road, Cumberland, Md. 21502

Pappas, Stephen S., 9701 Tusculum Way, Bethesda, Md. 20034

Peterson, Bonita J., Greater Baltimore Medical Center, Dept. of Pathology, Baltimore, Md. 21204

Quinton, Seana W., 1329 Lombard St., Apt. 105, Philadelphia, Pa. 19147

Roth, Henry, 3 Pooks Hill Rd., Bethesda, Md. 20014

Sauer, Robert Howard, U. S. Naval Hospital, Camp Lejeune, N. C. 28542

Sennett, Charlie Otis, Jr., 17505 Park Mill Drive, Derwood, Md.

Shen, Pearl Yuin-Tai, 8209 Fenway Rd., Bethesda, Md. 20034

Sones, Frank Mason, Jr., 2020 E. 93rd St., Cleveland, Ohio 44106

Stasko, Andrew, 401 Decatur St., Cumberland, Md.

Stone, Evan Clifford, 5704 Mohican Rd., Washington, D. C. 20016

Strauss, John Steaven, National Institute of Mental Health, Bethesda, Md.

Sutton, Jonathan McClellan, Rooney Apts., Webb's Lane, Dover, Del.

Tanning, Howard Michaels, 8906 16th Street, Silver Spring, Md. 20910

Urso, May Jewel Gong, 14107 Bramble Lane #203, Laurel, Md. 20810

Wanderer, Alan Anson, 14011 Bramble Lane, Laurel, Md. 20810.

Weinroth, Jerome Robert, 680 Azalas Drive, Rockville, Md. 20850

Wittenberg, Ralph E., 211 G Street, Washington, D. C. 20024

Young, Lois Adelaide, 4530 Fort Totten Drive, N.E., Washington, D. C. 20011

Names and addresses of above physicians received too late to appear in the Directory of Registered Physicians.

BALTIMORE CITY HEALTH DEPARTMENT

ROBERT E. FARBER, M.D., M.P.H.
COMMISSIONER

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752-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

Tuberculosis Tests for School Personnel

A new program of testing for tuberculosis among public school personnel was instituted April 18 by the City Health Department's Division of Tuberculosis. This step in the control of tuberculosis in the city was approved by the Board of School Commissioners on March 3.

Testing of school staff for tuberculosis will be by the tuberculin test, a chest x-ray, or both if indicated. It will be initiated in the schools by public health nurses using the tuberculin test. Reactors to the tuberculin test and those who for any one of a number of reasons omit the tuberculin test will be required to have a chest x-ray. Individuals who so desire may forego the tuberculin test and have a chest x-ray only.

Chest x-rays are available without charge at the Maryland Tuberculosis Association or at any of the four Baltimore City Health Department chest clinics. Those who wish to do so may have the test performed by their private physician, and those who can produce acceptable evidence of examination since September 1, 1965, need not repeat the tests at this time.

There is no evidence to suggest that tuberculosis is more prevalent among school teachers and other school staff than it is in the general public. However, as we know, when an infectious case does occur in a staff member in a school, there is greater opportunity for passing on the infection to the children. This did occur in a nursery in Detroit and was reported in the local newspaper this year on January 19.

About half of the newly reported active cases of tuberculosis occur in persons 45 years or older, most of whom have carried a dormant infection for years. Our current objective is to prevent infection of young children so that they will not develop disease.

The new tuberculosis testing program is under the supervision of Allan S. Moodie, MB. For further information on this program or any aspect of the Department's tuberculosis control work, call 752-2000, extension 2557.

Robert E. Farber, MD
Commissioner of Health



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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

Employee-Patient Ratios

The ratio of employees to patients in Maryland's four major psychiatric hospitals* has more than doubled since 1950. As shown in the following table, this change has been caused by an increase in the number of employees. The average size of the patient population in these hospitals, which increased until 1955, has since declined to approximately the same level as in 1950.

FISCAL YEAR	AUTHORIZED POSITIONS	AVERAGE SIZE OF PATIENT POPULATION	EMPLOYEES PER 100 PATIENTS
1950	1,719	7,844	21.9
1960	3,225	8,516	37.9
1964	3,553	7,821	45.4
1965	3,675	7,850	46.8
1966	3,784	7,836 (nine months)	48.3

This change is due, in part, to a fourfold increase in admissions (from 1,953 in 1950 to about 8,600 in 1966) and a sixfold increase in discharges (from 1,233 in 1950 to about 7,800 in 1966). Related to this has been a gradual decrease in the proportion of beds occupied by chronic patients and a concomitant increase in the proportion occupied by the acutely ill. Sixteen years ago, 65% of all patients had been hospitalized five years or more, 20% had been under care between one and five years, and the remaining 15% were hospitalized less than one year. These percentages are now 50, 25, and 25, respectively. Patients hospitalized for the short-term treatment of acute disturbances require much greater staff services than do chronic patients hospitalized for extended periods.

Statistics on employee-patient ratios should be approached with caution since they do not necessarily indicate the employee's function. For example, one-third of the Department's psychiatrists are either engaged in an administrative capacity or in the treatment of outpatients. Thus, although available statistics indicate one psychiatrist for every 70 hospitalized patients, the ratio of psychiatrists primarily engaged in hospital patient treatment to the number of patients is actually one to 105. Further, these figures vary substantially and are influenced by the size of the hospital.

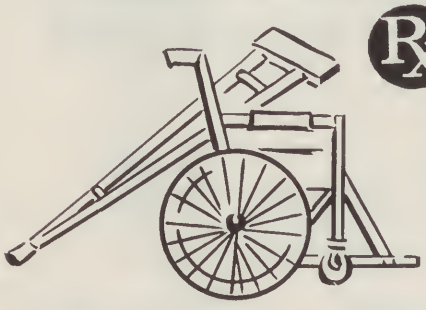
Available data indicate that the number of admissions will continue to increase. This can be expected to produce a gradual rise in the proportion of beds occupied by acutely ill patients receiving short-term treatment. Based on these data, a continuing increase in employee-patient ratios is indicated to maintain the present level of services.

* Crownsville, Eastern Shore, Springfield, and Spring Grove.



A special safety citation was made to the Medical and Chirurgical Faculty by the Maryland Traffic Safety Commission. President-elect J. Morris Reese, MD, received the award on behalf of the Faculty. The award was presented by Governor Tawes on February 21 at a luncheon meeting commemorating Hospital Appreciation Day.

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THE MEANING OF CONDOMINIUM

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There is much discussion these days concerning investments in medical centers. A relatively new term, "condominium," needs to be explained as it might apply to the physician investor.

Condominium means you own your office just as you would a home. It means you own space in a building where others also own space. You own fee simple title (absolute ownership) to the air space within the finished and unfinished surfaces of the ceiling, floors, and walls of your office unit. In some cases it could mean you own parking space underground or on an outside parking lot.

You own a percentage interest in all the common areas and facilities of the office building. You own a share of the land on which the building is located; the foundations, columns, girders, beams, supports, main walls, roof, halls, corridors, lobbies, stairs, stairways, fire escapes, and entrances and exits of the building.

You own a share of the central service installations for power, lights, gas, cold and hot water, heating, air conditioning and incinerating. You own a share of the elevators, tanks, pumps, motors, fans, compressors, ducts, generators . . . all apparatus existing for common use.

You are in every respect an owner (landlord) of real estate as opposed to a renter (lessee) of space or, as in a cooperative, a shareholder in a corporation with the right to occupy a specific office.

Following is a discussion of the *five important advantages* of condominium ownership over shareholding interest in a cooperative.

LIABILITY.—Every shareholder of a cooperative is liable for the default of any other shareholder. If a shareholder in an office fails to pay his share of the building's mortgage, taxes, and maintenance, this obligation must be met by the other shareholders.

In a condominium, you are NOT liable for the default of your neighbor. You are NOT financially entangled with other occupants of the building. You are responsible for only your own mortgage payments, tax bills, and share of the common maintenance.

INDEPENDENCE.—A shareholder in a cooperative requires permission from the other shareholders before he can sell or lease his office. Further, the prospective buyer must be approved by the other cooperative office owners.

FINANCIAL FREEDOM.—There is little financial flexibility in a cooperative. A single mortgage covers the entire project. A prospective tenant in a cooperative office project must accept the terms of the mortgage or reject participation.

As the owner of a condominium, you are free to manage your own financial affairs. You may arrange for your own financing on whatever terms suit you best. You may refinance your debt when you choose. You may prepay your mortgage if you wish. In fact you can pay the whole purchase price in cash and have no mortgage if you desire.

TAXES.—In a cooperative, the enterprise is taxed as a whole and members then pay their share of the levy.

In a condominium, each unit is assessed and taxed separately. You are taxed only for what

you own individually and your share of the jointly owned facilities and services. Of course, you are entitled to claim payments of mortgage interest and property taxes as professional income tax deductions as all office owners do. Your tax savings alone can reduce your monthly payments in many cases by as much as 50%

MANAGEMENT.—In a cooperative, the corporate officers, usually the developers and builders, maintain management control, set the rules, determine financing, designate the cooperative's policies, practices, and restrictions.

In a condominium, your rights and the rights of the other owners are specified in your individual warranty deed. This describes the method of managing and maintaining the building, prohibits office speculation, establishes the formula for prorating each owner's share of common expenses, allows you the right to examine management books at any time. All condominiums are managed by a management corporation controlled by a management committee comprised of the office owners.

So far only advantages have been discussed. What about disadvantages? In any business venture there are bound to be pitfalls. One example: Suppose some owners want to repaint common areas, but you disagree. If the management committee votes for it, you will have to go along with them whether you want to or not.

Now, some straight dollars and cents answers to the usual questions about office ownership in the condominium professional building:

Q. How is my share of ownership in common areas and facilities determined?

A. It is determined by taking the value of your office unit as a basis in relation to the total value of all the units in the building.



Q. Who pays for insurance on the building and the individual unit?

A. The management committee of office building owners will obtain fire insurance and other necessary insurance on the entire building, and premiums will be part of your common expenses. The insurance will be written in the name of the management committee and will be shared by you and all other owners. In addition, each unit will have an individual owner's policy to protect his personal responsibilities.

Q. Who pays for decorating, repairs, and changes to the building?

A. These payments come from the common expense funds.

Q. Am I responsible for common expenses on any other office?

A. No. The owner is only obligated to pay the proportionate share of common expense on his own office.

Q. How are common maintenance costs determined.

A. Common maintenance costs are based only on the actual cost of operating the property. Due to shared expenses, maintenance costs are at a minimum. Your management committee will meet once every six months to work out budgets and provide cost reports to all owners.

Q. What items of condominium ownership are tax deductible?

A. Both federal and state tax laws allow you, as an owner, to deduct interest and real estate taxes from your professional income. Since you use it as your professional business office, you earn a proportionate depreciation deduction from your income tax.

Q. How much of a down payment is usually expected?

A. You may pay as little as 10% of the total purchase price with the remainder assumed on mortgage, or you may purchase your space outright.

Q. What savings do I enjoy through condominium ownership?

A. In addition to substantial tax savings, you save by paying no landlord profit. You save by paying lowest possible maintenance costs. You save by arranging individual financing at more favorable rates and terms than afforded builders and developers. You save by eliminating the waste and inefficiency possible when management is not controlled by the office owner.



Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
Librarian

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Book Reviews

THE SOCIAL RESPONSIBILITY OF OBSTETRICS AND GYNECOLOGY, by Allan C. Barnes, MD. The Johns Hopkins Press. $5.95.

This book is composed of proceedings of a conference held May, 1965, at The Johns Hopkins Hospital. It is divided into six subsections, which are, respectively: The Quantity of the Next Generation; The Quality of the Next Generation; The Control of Neoplasia; The Law; The Agencies; and The Individual.

Eight of the 14 contributors are on the faculty of The Johns Hopkins University School of Medicine. This plus the addition of a succinct statement of the legal dilemmas facing obstetricians in Maryland by the former president of the Maryland Bar Association and an enlightening paper on "Sex Education in Baltimore City Schools" by the president of the Baltimore City School Board make this volume of particular interest to Maryland physicians.

Contributions by a representative of the Population Reference Bureau in Washington, a faculty member from the Bowman Gray Medical School, a representative from the American Cancer Society, and a chairman of department from the University of Rochester adequately attest the national concern on the part of obstetrician-gynecologists for the pressing sociological problems which are parametrical to or directly related to the discipline of this specialty.

Each subsection is introduced by Dr. Barnes in his usual erudite, succinct, and to-the-point manner. The component subjects in each section have obviously been carefully chosen and are delivered by people well qualified to express opinions in their particular field. The material ranges from an initial no-nonsense statement of the magnitude of the worldwide population crisis by Mr. Robert C. Cook, through an excellent paper by Ethel M. Nash on "Divorce and Marriage Counseling," to a thoughtful paper by Dr. John Ramano on necessary changes in graduate and undergraduate medical training, which must ultimately reflect changes in traditional obstetric and gynecologic teaching if we are to successfully approach the problems that society expects us to answer. The multiplicity of problems of this nature which were once tangential to obstetrics and gynecology but now confront it could provide material for a volume many times the size of this little book. The respective authors are to be congratulated on keeping their material brief and thought-provoking.

It is unfortunate that the enthusiasm expressed by Clifton B. Read for the Home Test Irrigation Kit for cervical cancer must be tempered by the recent disclosure of the disappointing statistics in reference to patient acceptance. This, however, in no way detracts from the general value of the volume.

No attempt was made to solve the serious questions facing us. The stated goal of setting forth the problem, exploring it, and delineating it has been accomplished.

I particularly appreciate the concluding paragraph in the epilogue:



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"We are, in a sense, a society of the walking wounded, collectively over-crowded and individually hurt and the correction of the situation is the urgent task to which we should commit our thoughtful energies. The time to start was yesterday."

The book is recommended not only for obstetrician-gynecologists but for all physicians. It ought to be required reading for those now in Ob-Gyn residency programs or those contemplating practice in obstetrics and gynecology.

L. Louis Mould, MD

FAMOUS MODERN MEN OF MEDICINE, by Caroline A. Chandler, MD. Dodd, Mead & Co. $3.25.

Caroline A. Chandler's book, *Famous Modern Men of Medicine*, is an exceedingly dull group of biographies of great modern doctors. Included are such physicians as Howard A. Rusk, Paul Dudley White, Anna Freud, and Helen Taussig and Alfred Blalock. Despite the basically engrossing subject, Dr. Chandler has managed to ignore all good approaches. Instead she has written, and poorly, an easily forgettable book.

The biographies are supposedly for the teenage reader with an interest in medicine. Apparently, however, Dr. Chandler knows only teenagers of the below average reading level, for the treatment is one of simplified baby-talk.

Most of the book is composed of quotations from "personal interview with author" notes, a fact which the author points out at every available opportunity. Moreover, Dr. Chandler makes mistakes that an average reader would soon pick up. She compares Leonardo da Vinci, a fifteenth century Italian Renaissance man, with William Montague Cobb, describing them as "thirteenth century-style, all-around 'complete' men." Her worst error is slanderous in content. Dr. Chandler describes Benjamin Spock as being "as far removed from babies in physical appearance as he is close to them intellectually and emotionally." Is Dr. Chandler trying to tell us something?

As pure encyclopedic reading, *Famous Modern Men of Medicine* can be recommended. However, for the reader who wants to enjoy a book as well as learn, this book is not the one to get.

Hilary Sargeant

Editor's Note: Miss Sargeant is a senior at Eastern High School.

COMMUNITY MENTAL HEALTH SERVICES IN NORTHERN EUROPE, U.S. Department of Health, Education, and Welfare. $1.75

This is an account of Sylvan S. Furman's observations of mental health programs, in Great Britain, Netherlands, Denmark, and Sweden, written under contract with the National Institute of Mental Health. It offers some selective observations that the author thinks might be helpful and interesting to the American reader, particularly those interested in community mental health planning.

Specifically, the purposes of this report are: 1) to provide concise information about systems of care for the mentally ill in the countries visited, the varieties of such systems, and how the parts of the system are administratively related; 2) to show how the systems of care relate to the basic public health, medical care, and social welfare systems of the respective countries; 3) to suggest how some of these systems and methods may be adaptable to local needs in America.

AN ATLAS OF FINE STRUCTURE: THE CELL, by Don W. Fawcett, MD. Saunders, 1966. $11

This is one of a projected series of atlases of fine structure incorporating the new knowledge made possible by the electron microscope. It is intended as a laboratory manual for students in cell biology, histology, and cytology, rather than as a textbook or a reference. It is primarily a book of illustrations with a minimum amount of descriptive text.

MEDICAL PHARMACOLOGY, ed 3, by Andres Goth, MD. Mosby, 1966. $12.50

This book is intended as a concise text for students and physicians. To achieve his goal, the author has eliminated the many details of interest only to the professional pharmacologist. He emphasizes those areas of pharmacology that are expanding and are contributing the most to modern medicine. One new feature of this edition is a separate grouping of recent reviews at the end of chapters.

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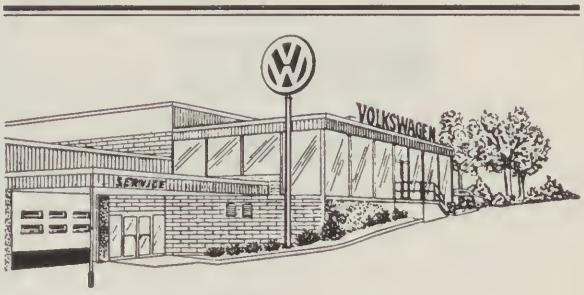
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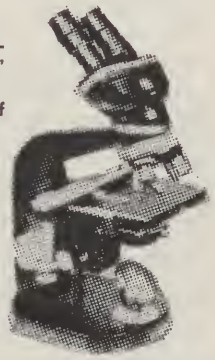
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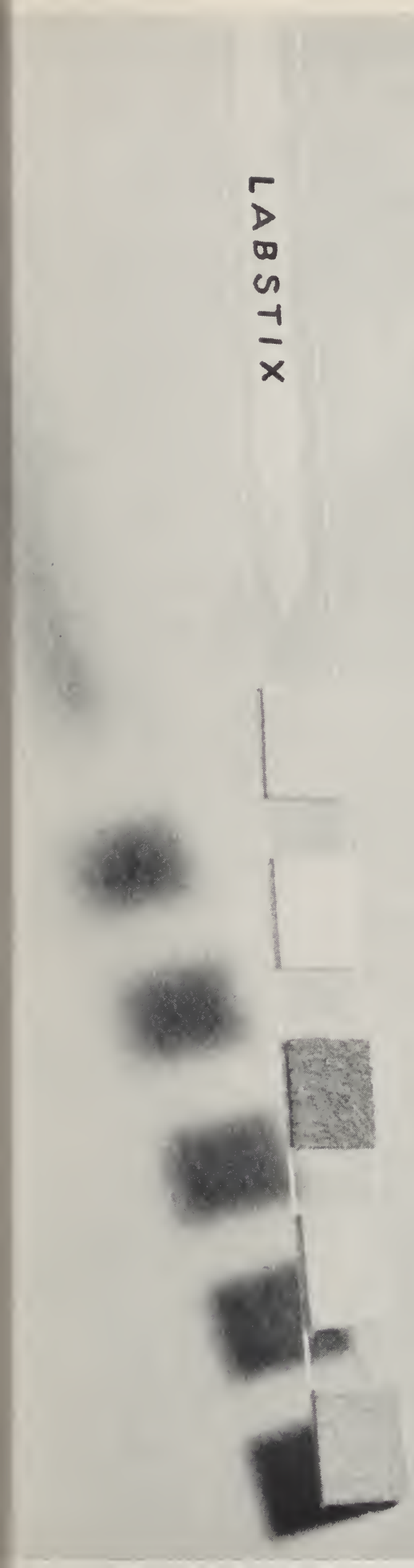
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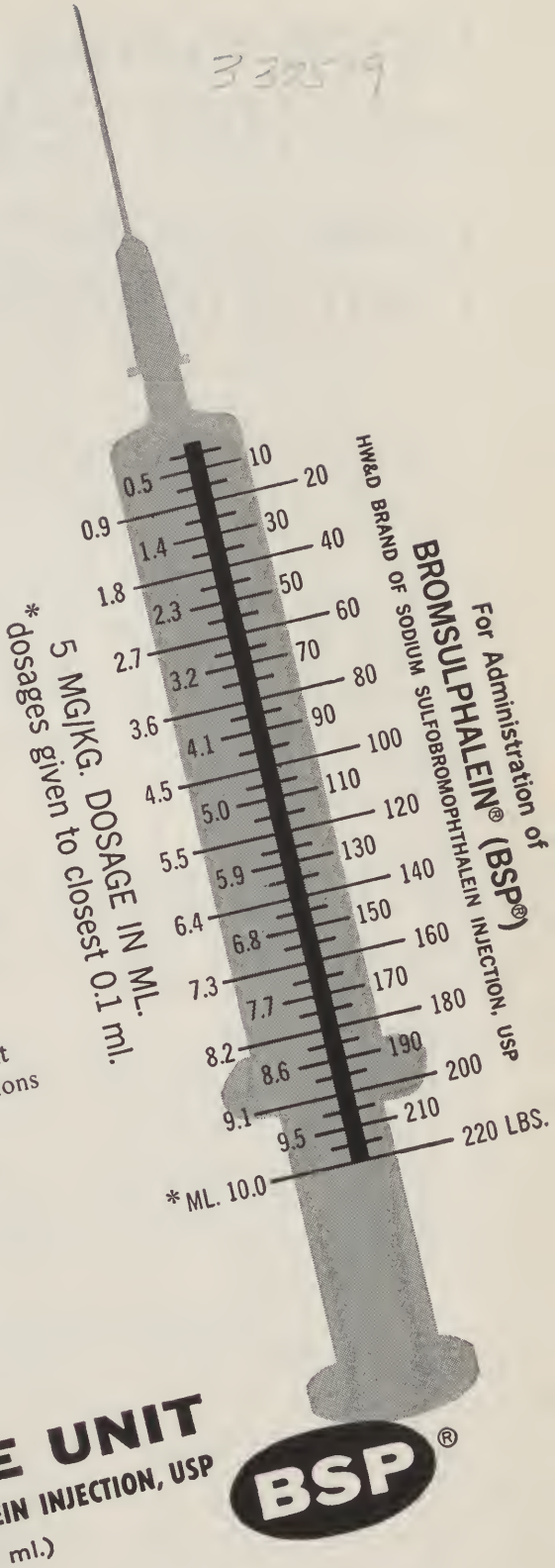
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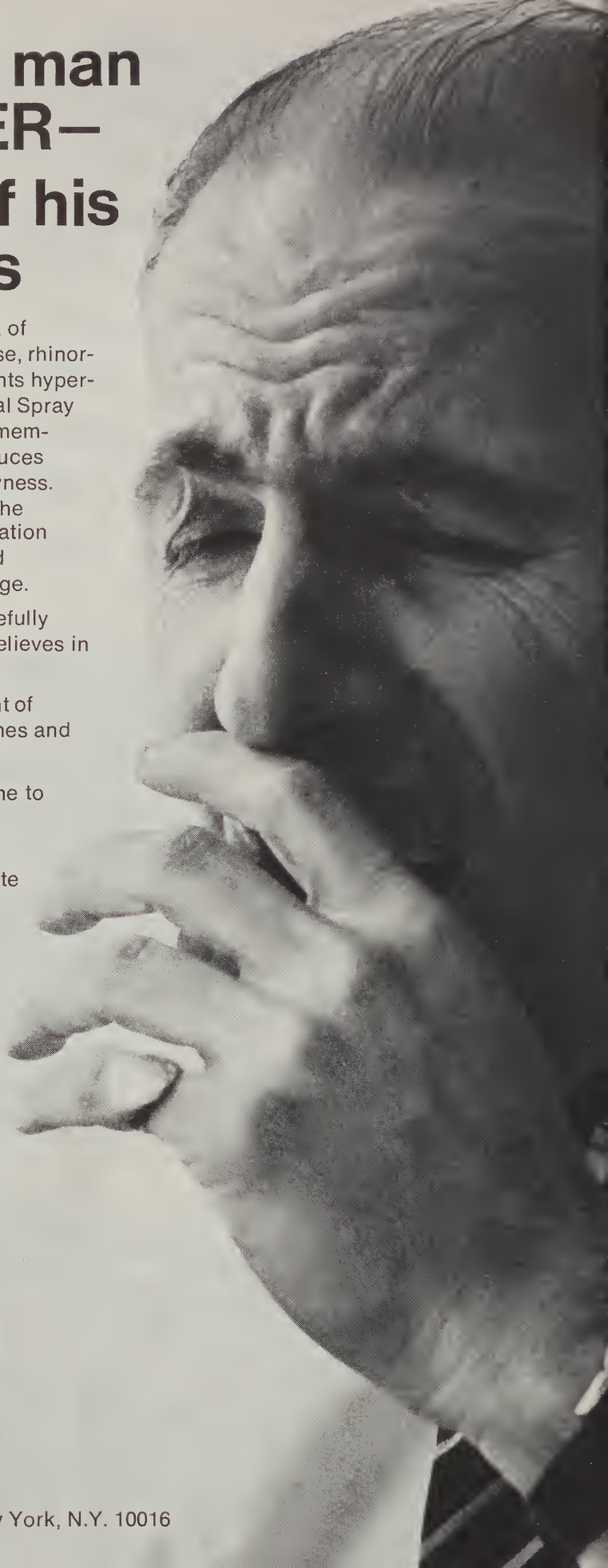
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Maryland
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July, 1966

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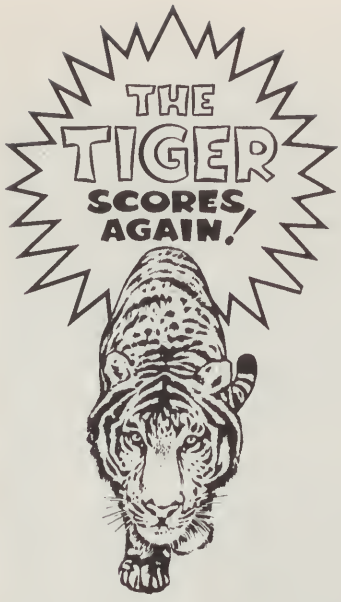
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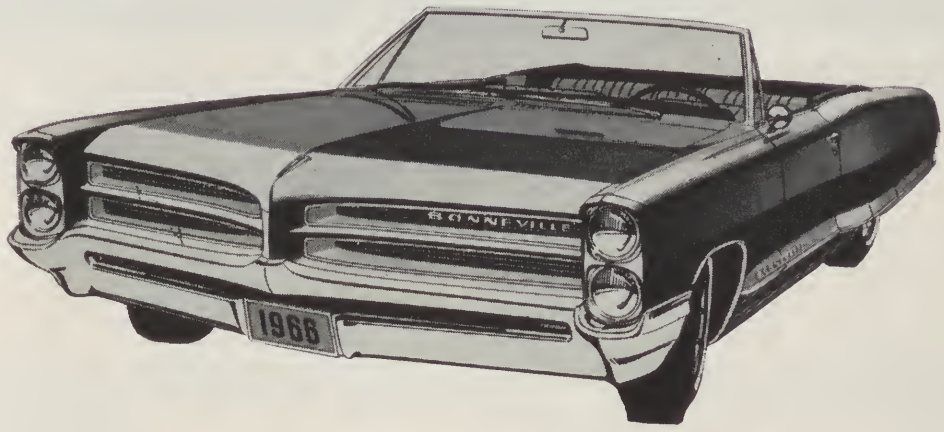
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September 10—Semiannual meeting, Medical and Chirurgical Faculty of the State of Maryland, Ocean City.

MEALS ON WHEELS KITCHEN OPEN IN CATONSVILLE

The Commission on the Aging in Baltimore County has opened its first Meals on Wheels kitchen in the Catonsville area. The county program has received a federal grant of $2,480 through the State Commission on Aging to initiate this program. A hot and cold meal will be delivered each day, five days a week. Clients will pay $7.50 per week for meals, which have been planned by nutritionists, prepared by a paid cook, packaged and delivered by volunteers. This program is geared primarily to aging men and women who need this service in order to remain in their own homes; however, any homebound person may qualify for these meals.

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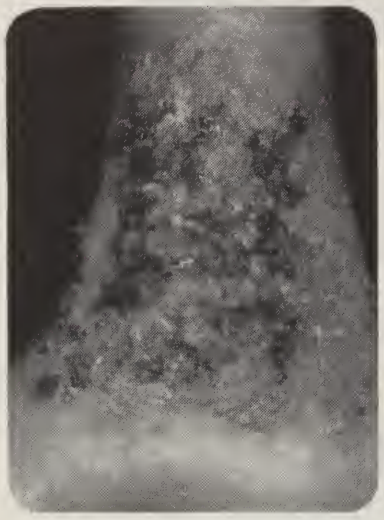
GRADUATE COURSE IN MEDICAL HYPNOSIS

A graduate course in medical hypnosis is being offered to physicians and dentists by the University of Pennsylvania Graduate Division, School of Medicine. It will consist of 20 four-hour weekly afternoon sessions, beginning September 28. It is one of the few courses offered which meets with recommendations made by the American Medical Association's Committee on Hypnosis.

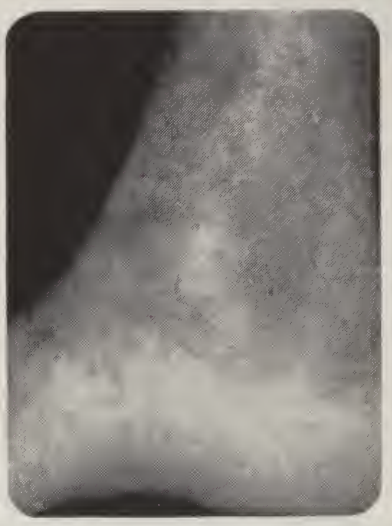
During the first part of the course, basic concepts of hypnosis will be taught through lectures on psychiatry and hypnosis, demonstrations, and supervised practical work in hypnosis. Later sessions will cover clinical applications of hypnosis. There will be sessions limited to psychiatrists and other sessions limited to general practitioners, dentists, and specialists other than psychiatrists.

Both courses will be given at the Institute of the Pennsylvania Hospital, 111 North 49th Street, Philadelphia, Pa 19139. For further information, write to: Sydney E. Pulver, MD, at this address.

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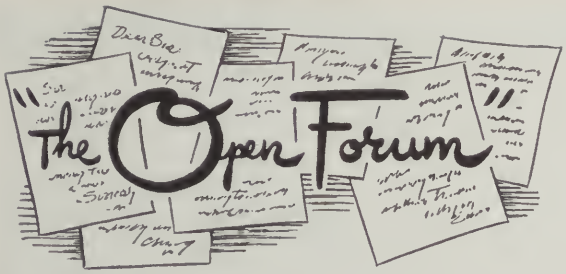
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To The Editor:

I have just read an article printed in the second (February) issue of the *Maryland State Medical Journal* and am very much concerned with particular areas of this article. The name of the article is "Medical Care in a Baltimore Nursing Home," by Douglas G. Carroll, MD, which appeared on page 63.

First, let me say that this article did not represent a cross section of the nursing homes in Maryland. This particular nursing home was closed by the State Health Department because it was not living up to the requirements set forth. In these requirements, this nursing home was licensed for eleven patients and had a total of twenty-four patients when investigated by the State Health Department. This nursing home was not properly licensed and also, at that time, had a temporary license because the Health Department questioned the medical care that was being given to the patients at this home.

In this article, on page 63, it says "It is probable, therefore, that the inadequacy found in this home exists to some extent in all nursing homes." This is an implication that should never be implied, unless further proof can be found. Dr. Carroll took the worst home in Maryland; one that was ostracized by the Nursing Home Association; one that was closed down by the State Health Department, and compared it to the fine, modern, and properly licensed nursing homes throughout the state. Such a situation as described in this article could not easily happen in a properly licensed and administered nursing home in the state.

We have medical records that are up to date on each of the patients in the nursing homes in Maryland, and doctors, in accordance with state regulations, must examine the patients at least once a month. If certain disorders were not discovered at the home, it would certainly be the fault of the patient's physician rather than the nursing home.

I ask that some mention be made, that this nursing home which was compared with other nursing homes in the state, was a nursing home that was below par for all the homes in Maryland.

Whatever you can do to correct this gross interpretation of how nursing homes really are, as presented in this article, would be greatly appreciated.

Thank you.

Richard Rynd
Legislative Chairman
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Maryland State Medical Journal
Vol. 15, No. 7
July, 1966

Editorial

About the AMA-ERF

Your AMA-ERF is four years old. It is a very young Foundation which has much to be proud of —and a glance at its record reveals the important activities.

In its brief history, the Foundation

- transmitted more than $1 million a year from physicians and their wives in unrestricted funds to medical schools;
- guided more than $3 million from physicians and industry into $30 million in loans for medical students, interns and residents;
- created the mechanism that channels funds into research on smoking and health;
- supported the Summer Institute for Medical Journalism, which aims at increasing the writing and editing abilities of young physicians;
- established a program in bequests to medical research, a service to bankers and lawyers in guiding their clients' bequests;
- set up the mechanism to accept small contributions to research that by themselves would purchase little but which, when pooled, become capable of sponsoring research projects, and
- in the last year has built and opened the Institute for Biomedical Research, an exciting venture in basic biomedical research.

Physically the Institute has space and laboratory equipment in the new addition to the AMA headquarters building. The Institute is designed to provide maximum opportunity for outstanding scientists to devote their full energies to basic research in cellular biology without the distractions of teaching or performing administrative chores.

The facility is supported entirely by private funds.

Five scientists are at work in the Institute, and several more are expected to join them in the near future. Eventually about 25 scientists will be accommodated.

What is ahead for the Foundation? That depends on you. The success of these programs is in the hands of those physicians who endorse them—intellectually and financially. Where do you stand in the fourth year with your Foundation?



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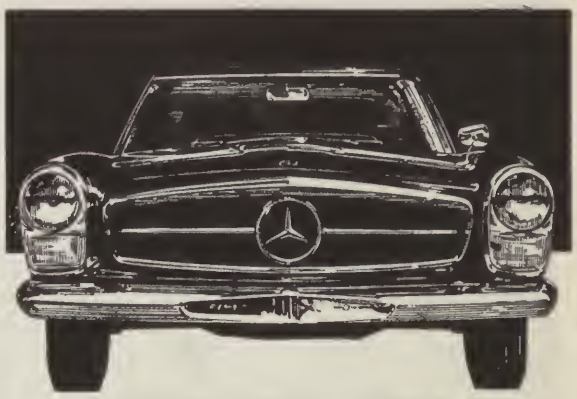
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EXECUTIVE SECRETARY'S NEWSLETTER

July, 1966

SEMIANNUAL SESSION

The Semiannual Meeting is scheduled for Friday, September 9, in Ocean City, at the Diplomat Motel. The schedule of activity is as follows:

8:30 p.m., Thursday, September 8
Council
9:30 a.m., Friday, September 9
House of Delegates
1:00 p.m., Friday, September 9
Crab Feast Luncheon, Phillips Crab House
6:30 p.m., Friday, September 9
Poolside Cocktail Party at The Diplomat
7:30 p.m., Friday, September 9
Dinner Dance, and an illustrated lecture by A. McGehee Harvey, M.D., on "Medicine and the Three Worlds of Peru: Past, Present and Future."

Other groups meeting jointly with the Faculty on Saturday, September 10, include:
Maryland Chapter, American College of Surgeons
Maryland Diabetes Association
Maryland Psychiatric Society

It's not too early to make your hotel reservation. See reservation slip elsewhere in this Journal.

LEGISLATIVE CORRECTION

It was reported in The Assemblyman, Volume IV, Issue 3, page 2, that Senate Bill 61, dealing with a change in the Abortion Law, had been adopted by the General Assembly. This is incorrect as this bill did not pass the State Legislature and died in the last few hours of that session.

NEW INCOME LIMITS FOR MEDICAL CARE PROGRAM

House Resolution 102 adopted by the 1966 General Assembly provides medical indigency income limits for the State budget commencing July 1, 1966, as follows:

One person	$1,800. per annum
Two persons	2,280. per annum
Three persons	2,640. per annum
Four persons	2,940. per annum
Five persons	3,480. per annum
Six persons	3,900. per annum

Each additional person $ 420. per annum

Don't forget increase in office visit fee, effective the same date, to $3.00 from $2.50.

NEWS NOTES

Joseph S. McLaughlin, Baltimore, has been named a Markle Scholar. Markle Scholarships are awarded to a maximum of 25 a year to "help prepare promising young teachers and investigators for positions of leadership in academic medicine."

The Washington-Baltimore Society of Physical Medicine and Rehabilitation have elected the following officers for the 1966-67 year:

Frederick J. Balsam, Baltimore, President
David A. Zohn, Washington, Vice-President
B. Stanley Cohen, Baltimore, Sec.-Treas.

Peter A. Santucci, Bethesda, has been elected Secretary of the Guild of Catholic Psychiatrists.

A new Active Member of the American Society of Anesthesiology is Narciso V. del Carmen, Westminster; and Isagani R. Bernardo, Baltimore, a Junior Member.

ADDITIONAL RESOLUTIONS

Additional resolutions received for consideration by the House of Delegates are:

Resolution 4S/66 - Development of a Program By Maryland Medical Service (Blue Shield) To Pay Reasonable And Customary Fees To Physicians

Resolution 5S/66 - Payment of Reasonable and Customary Fees For Professional Services Under Title XIX of PL 89-97

The Reference Committee will meet on Thursday, July 28 at 8:00 p.m., in the Faculty building.

John Sargeant

Executive Secretary



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- The best system of medical bookkeeping by computer.
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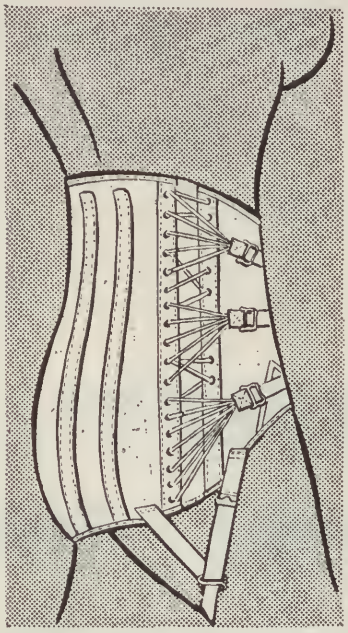
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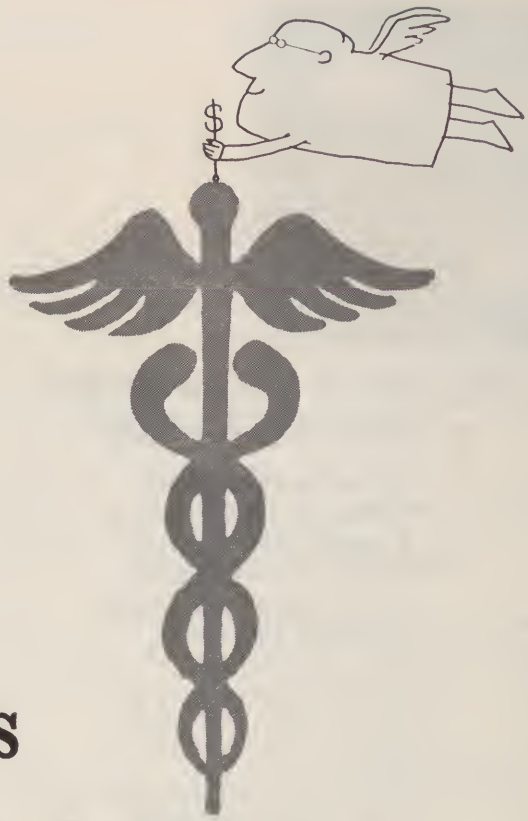
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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

House of Delegates, April 26*

1. A moment of silence was observed in memory of deceased colleagues.

2. A motion of the Treasurer recommending a Nominee Form for securities was adopted.

3. Emeritus membership was bestowed on the following physicians: J. Edmund Bradley, MD, and Nicholson J. Eastman, MD, Baltimore City; Mary McK. Cushing, MD, and Robert Hening, MD, Baltimore County; Simon Virkutis, MD, Dorchester County; Manfred J. Gerstley, MD, and Eugene Kester, MD, Kent County; J. Marion Bankhead, MD, Edith H. Weigert, MD, and Naomi Lucius, MD, Montgomery County; H. Dabney Kerr, MD, Talbot County.

4. An additional sum up to $10,000 was appropriated through December 31, 1966, to continue and expand the MEDIC network.

5. Thirteen physicians were honored for 50 years of membership in the Faculty. Pins were awarded to those able to be present.

6. On behalf of the AMA, the President presented plaques of recognition for voluntary service in Viet Nam for 60 day to Robert E. Eby, MD, and Stephen M. Nagy, MD. A plaque is to be presented at a later date to Richard W. TeLinde, MD, who was unable to be present.

7. Various Bylaw amendments were adopted. The text of these may be found in the Minutes and in the report of the Bylaws Committee.

8. Resolutions of the Fee Schedule Committee were adopted, one reaffirming the principle that usual and customary fees be paid to private practicing physicians rendering care to medical care program patients; the other calling for appointment of a subcommittee of the Fee Schedule Committee to deal with PL89-97 matters.

House of Delegates, April 29*

1. The slate of officers proposed by the Nominating Committee was elected unanimously.

2. A resolution supporting separation of professional fees from hospital charges was adopted.

3. A resolution calling for establishment of a School of Medical Technology at the University of Maryland was adopted. Additional recommendations of the Reference Committee concerning implementation of this resolution were also adopted.

4. A resolution proposed by the Montgomery County Medical Society, calling for the Faculty's AMA delegates to introduce a resolution urging each constituent society to establish Medicare Coordinating Committees in their communities, was adopted.

5. M. B. Levin, MD, was granted the privilege of addressing the House. He raised three points of order, which the Chair ruled were not well taken.

*See pages 52-112 for full text of minutes and reports.

SKIN PROBLEMS

Caused by itching due to:

Dry Eczema	Acne
Chafing	Ivy Poisoning
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Athlete's Foot	Heat Rash
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EXECUTIVE COMMITTEE, MAY 19

1. Report was made that an appropriate Faculty group is meeting with Health Department officials to determine fee arrangements under the Medical Care programs.

2. Dr. Russell Nelson is to be invited to discuss with the Executive Committee plans for a proposed satellite of the Johns Hopkins Hospital to be opened in Howard County that would offer prepaid medical care.

3. The Chief, Division of Community Health Services, HEW, attended a portion of the meeting to find out physicians' opinions on maintaining quality of care under PL 89-97. It evolved that physicians are mainly concerned about utilization of physicians' services once the patient has met the $50 deductible and about interpreting the Medicare law to patients. The matter of explaining the law to patients was, in the opinion of the Executive Committee, a matter to be undertaken by HEW or the fiscal carrier, not the physician.

4. The question of whether state legislation should be sought to spell out the fact that the practice of medicine is the responsibility of the physician—not of the hospital —was answered by Faculty's legal counsel. The decision in Illinois, inferring that hospitals were responsible for the practice of medicine in their institutions, was too nebulous to warrant legislative action.

5. The Membership Committee reported on a question which had been referred to it concerning the granting of Physicians' Defense to all associate members. The opinion was that this had not significantly increased the Faculty's legal costs and it was a strong selling point in attracting and retaining members. The Executive Committee concurred in the recommendation that this provision of the Bylaws should remain.

6. Suggestions were made for gubernatorial appointments of physical therapists to the Board of Physical Therapy Examiners.

7. Members of the Building Committee are to be polled with the suggestion that this Committee be disbanded and custody of funds be turned over to the Treasurer, to be maintained in separate Building Fund accounts.

8. A report was made of discussions concerning rules and regulations for laboratories to be promulgated by the State Health Department. The only question not resolved was what did or did not constitute solicitation under the terms of the law.

9. The State Health Department is to be asked to incorporate in its proposed rules and regulations the ethical standards with respect to solicitation and advertising as adopted by the Faculty's Council.

10. Approval was given to sending a letter from the President to all members advising them of their obligations in connection with the battered child law and the laboratory rules and regulations.

11. No recommendation is to be made this year for the Governor's Award to a Physician for Promotion of Employment of Physically Handicapped. In the future, recommendations are to originate from the Occupational Health Committee and be presented to the Council.

12. Approval was given to having a staff member attend sessions of the Advisory Council on Heart Disease, Cancer, and Stroke.

13. The practice of holding joint meetings with the Executive Committee of the Hospital Council is to be continued.

14. The following recommendation of the Fee Schedule Committee was approved: That permission be requested from the Executive Committee or Council to approach "A Continuing Committee to Study the Medical and Surgical Fees Applicable to Workmen's Compensation" with a view to discussing payment of the usual and customary fees, as defined by the Medical and Chirurgical Faculty, for all Workmen's Compensation cases.

15. J. Morris Reese, MD, was appointed to the Advisory Committee, Community Information and Referral Service, Health and Welfare Council of the Baltimore Area, Inc.

16. A resolution from the Louisiana State Medical Society urging all other state societies to initiate a program of collecting drugs and medical supplies for Viet Nam is being referred to the Woman's Auxiliary.

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Anatomy of
Low Back Pain #1



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set up by the heavy, forward-tilted he
and trunk, balanced precariously on
insufficient base, result in strain of t
dorsal musculature, particularly at t
low lumbar level.

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prescribed ☐ **to relieve pain** ☐ **to rel
muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management
muscle spasm, pain, and stiffness in a variety
inflammatory, traumatic, and degenerative mus
loskeletal conditions. It also may act to normal
motor activity in certain neurologic disturbanc

Contraindications: Allergic or idiosyncratic re
tions to carisoprodol.

Precautions: 'Soma', like other central nerv
system depressants, should be used with caut
in patients with known propensity for taking
cessive quantities of drugs and in patients w
known sensitivity to compounds of similar che
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with
frequency is sleepiness, usually on higher t
recommended doses. An occasional patient r
not tolerate carisoprodol because of an individ
reaction, such as a sensation of weakness. Ot
rarely observed reactions have included dizzine
ataxia, tremor, agitation, irritability, headache,
crease in eosinophil count, flushing of face,
gastrointestinal symptoms.

One instance each of pancytopenia and le
penia, occurring when carisoprodol was ad
istered with other drugs, has been reported, as
an instance of fixed drug eruption with carisopro
and subsequent cross reaction to meprobam
Rare allergic reactions, usually mild, have inclu
one case each of anaphylactoid reaction with r
shock and angioneurotic edema with respira
difficulty, both reversed with appropriate ther
In cases of allergic or hypersensitivity react
carisoprodol should be discontinued and appro
ate therapy initiated. Suicidal attempts may
duce coma and/or mild shock and respira
depression.

Dosage: Usual adult dose is one 350 mg. ta
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SURVEILLANCE FOR ARTHROPOD-BORNE ENCEPHALITIS IN MARYLAND

PAUL D. STOLLEY, MD
JOHN H. JANNEY, MD
J. M. JOSEPH, PhD

This is the mosquito season and the time to be alert for viral encephalitis. The Maryland State Health Department is conducting a surveillance program and has issued instructions for collecting specimens for laboratory examination. One known case occurred in Maryland last year and is reported here.

In 1965, the Division of Epidemiology and the Bureau of Laboratories of the Maryland State Health Department initiated a surveillance program for the arthropod-borne encephalitides. Personal visits were made to the pathologists and medical directors of most Maryland hospitals, and circulars were mailed which warned of the possibility of this disease's occurring and gave instructions as to the type of specimens to be shipped to the State Health Department Laboratory for diagnosis.

In previous years, surveys of the mosquito vector and birds had demonstrated the presence of Eastern encephalitis virus in Maryland, especially in the Eastern Shore swamp area.

Instructions for Collection of Specimens for Laboratory Examinations for Viral Encephalitis

FROM CLINICAL CASES

Collect 10ml blood during the early febrile phase of the illness. Split the 10 ml collection into two 5ml samples, putting each into an STS blood tube with rubber stopper and without preservative or anticoagulant.

Sample A.—One tube is used for virus isolation. Fresh blood is the best material from which to attempt this isolation. It should be frozen immediately after collection and shipped in a frozen state to the Central Laboratory, 16 E 23rd St, Baltimore, promptly after collection. If the specimen cannot be transported immediately, it should be stored in the freezing compartment of the refrigerator until it can be sent. This specimen must be labeled "Encephalitis virus studies" on the data slip.

Sample B.—The second sample is used for serology. It may be mailed to the Central Laboratory in the same manner as STS bloods are sent. Do not allow the clotted blood (sample B) to freeze. However, if the specimen is centrifuged and the serum taken off, this serum may be stored frozen. A second 10ml sample of blood should be drawn 14-21 days after onset and sent in for serology. It is necessary to have acute and convalescent specimens (paired sera) in order to determine a rise in antibodies. This specimen should be marked "Encephalitis serology" on the data slip.

FROM AUTOPSY MATERIALS FOR VIRUS ISOLATION

Whole blood or serum (10ml), if available; spinal fluid; stool, brain cortex, brain stem, or whole brain; lung, spleen, or other organs showing signs of involvement.

Autopsy specimens should be frozen fresh. Do not put them in formalin.

When there is autopsy material available for examination, notify Dr. John H. Janney, Division of Epidemiology, 837-9000, Ext. 8406, or Dr. J. M. Joseph, Central Laboratory, 837-9000, Ext. 8576. Instructions will be given as to shipment, or arrangements will be made for the material to be picked up by the Health Department.

Any inquiries regarding collection or handling of specimens should be referred to one of the above numbers.

Submit two stool specimens, taken on consecutive days, which will be used for attempts to isolate possible enteroviruses. These specimens can be mailed without refrigeration.

Case Report

This was the only documented case of mosquito-

From the Division of Epidemiology and Bureau of Laboratories, Maryland State Health Department.

borne encephalitis known to have occurred in Maryland in 1965.

On August 28, a 74-year-old Negro woman, resident of Stockton in Worcester County, was admitted to Peninsula General Hospital in a comatose state. The onset of her illness was three days before admission, when her family noted confused and strange behavior. One day before admission she was seen by her private physician, who had been treating her for adult-onset diabetes with oral hypoglycemic agents. At that time her oral temperature was 102°F. She was treated with parenteral penicillin, but the family returned the patient to the physician's office on the day of admission. She was in a coma and still febrile.

The following physical findings were recorded: P-120 BP: 220/110 R-30. Temperature: 104°F. The patient was an elderly Negro female in a comatose condition and showing no voluntary motion on the right side.

Neck: Nuchal rigidity was present.

Cardiovascular: The heart appeared enlarged with the apical impulse felt at the left anterior axillary line. A high-pitched systolic murmur was heard at the apex and was transmitted to the axilla.

Abdomen: No organs or masses were palpated.

Neurological: The patient exhibited a markedly depressed level of consciousness and would not respond to verbal commands. The deep tendon reflexes were generally decreased and a right hemiparesis was present with a positive Babinski sign on the right.

Laboratory Data: The initial WBC was 16,000 with 92 polymorphonuclear leukocytes, one stab form, and seven lymphocytes. Three days later, one day prior to death, the WBC was 5,000. The admission hematocrit was 37%. The cerebrospinal fluid was examined on the day of admission and had a xanthochromic appearance. There was a total of 768 cells/cu mm with 174 of these red cells and 594 white cells. The differential showed 60% of the white cells to be lymphocytes and 40% polymorphonuclear leukocytes. The CSF protein was 147 mg%, the glucose 183 mg% (with a simultaneous blood sugar of 340 mg%) and chlorides 125 mEq/1. A single hemagglutination-inhibition antibody titer to E.E. was 1:640.

On the day of admission, the BUN was 16 mg/100ml and the electrolyte determinations were within the normal range.

No bacterial pathogens were isolated from the CSF, and several blood cultures were negative. Eastern encephalitis virus was isolated from postmortem brain tissue.

X-ray: A chest film showed clear lung fields and minimal cardiac enlargement.

Clinical Course: The patient remained comatose throughout her hospital course. During hospitalization she received isoniazide, para-amino salicylic acid; penicillin, streptomycin, chloramphenicol, and insulin. Nevertheless, her condition deteriorated. Her pupils became fixed and small, and she failed to respond to pain throughout her illness. Her temperature had ranged from 103°F to 104.8°F until the final hospital day, when it dropped below 98°F. She died on the fifth hospital day.

Pathology: A widespread but mild encephalitis was present throughout the central nervous system, characterized by the inflammatory changes typical of arthropod-borne virus infection. Eastern encephalitis virus was isolated from her brain tissue.

Discussion: The isolation of the Eastern encephalitis virus from the patient's nervous tissue established the diagnosis postmortem. In addition, several horse cases of Eastern encephalitis were known to have occurred within 25 miles of her home. Studies of the usual vector, *Culiseta melanura,* in an area north of her home where a pheasant flock was almost destroyed by Eastern encephalitis, showed an infection rate of 1:167 from over 2,000 collected mosquitos. In addition, 57 isolations of Eastern encephalitis virus were made from mosquitoes collected from the Pocomoke cypress swamp, a few miles west of her home. This patient presented initially with a picture similar to that seen with a cerebrovascular accident. The diagnosis was subsequently proved to be arthropod-borne encephalitis.

Conclusion

The demonstrated presence of infected vector mosquitoes and reservoir birds, and known horse cases in previous years make the likelihood of cases of Eastern encephalitis occurring this summer probable. Alertness will aid in diagnosis of this disease.

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Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

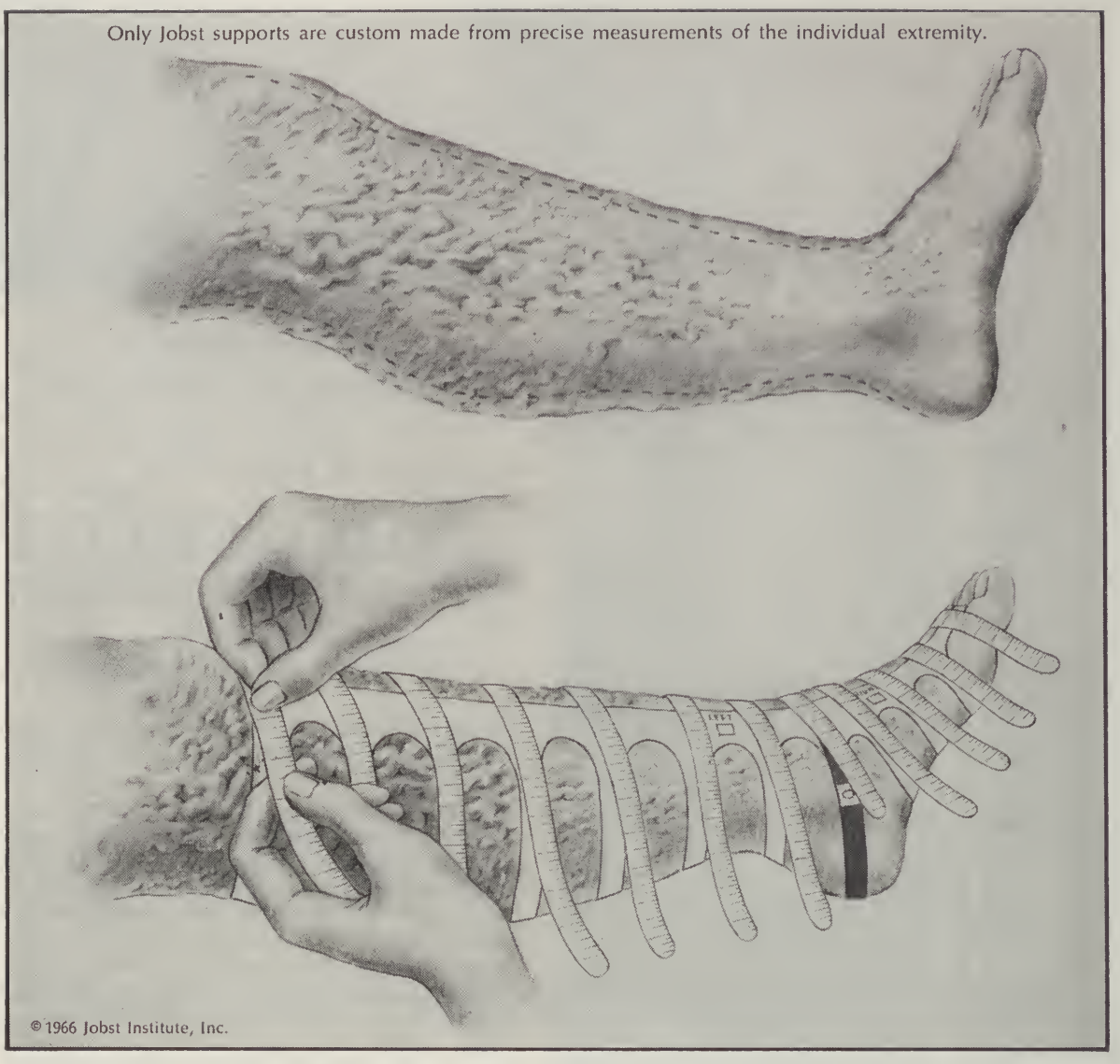
Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

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References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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Medicine's Responsibility in Solving *Population Problems*

While the medical profession has successfully reduced death rates, it has tended to ignore the other half of the problem of natural balance—birth rates. If populations continue to increase, famines, poorer living standards, and growing tensions threaten our civilization and possibly the survival of the human race.

H. CURTIS WOOD, JR., MD
Medical Consultant to the Association for Voluntary Sterilization

Nearly everyone has heard of the population explosion. Why this term is used is not so widely known. It took well over one million years for the peoples of the earth to slowly increase until by the year 1800 AD the world population was about one billion. In only 100 years the increase was then as great as since man first appeared on earth, and by 1900 the population was approximately two billion. The third billion was added in only 60 years, and now, at present rates, in 35 years the world population will double and reach six billion; some experts predict it may be seven billion. How serious is this?

In 1961 a petition was sent to the heads of state of each member of the United Nations. It was signed by distinguished citizens from 19 countries, authors, educators, scientists, and political leaders, including 38 Nobel Prize winners. This petition urged the United Nations to take leadership in a program to limit population increases the world over, "in order that human beings everywhere may be assured of the opportunity to develop their highest capacities and to enjoy individual freedom, the advantages of education and public health, privacy, abundance, security and the beauty and wonder of the world." The petition went on to say that medically sound and individually acceptable birth control is an essential factor in any humane design to raise living standards and achieve international peace as well as social and family stability and that in spite of technological advances, the earth cannot provide food and minerals for a population increasing more than geometrically. "Unless a favorable balance of population and resources is achieved with a minimum of delay, there is in prospect a Dark Age of human misery, famine, undereducation, and unrest which could generate growing panic, exploding into wars fought to appropriate the dwindling means of survival."

More and more thinking people agree that the population problem is the basic problem of the world. Without widespread fertility control we cannot hope to maintain even today's living standards, nor can we raise them. The late President Kennedy realized that without population limitation the objectives of our foreign aid programs could not be achieved. In 1961, speaking of the situation in Latin America, in a special message on foreign aid, he said, "Population growth is already threatening to outpace economic growth,

I. Ridgeway Trimble Fund Lecture, presented at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 27, 1966.

and in some parts of the continent living standards are actually declining."

While the world population will probably double by the year 2000, Latin America's present 200 million will, at present rates, triple in these same 35 years and reach the staggering total of 600 million. Unless there is swift action to promote adequate fertility control, what hope is there for raising living standards and improving international relations and social or family stability?

James Reston, the newspaper columnist, echoed these thoughts when he wrote: "The greatest menace to world peace and increased standards of living is not atomic energy, but sexual energy," and Robert C. Cook, of the Population Reference Bureau agrees when he says: "The most ominous force in the world today is uncontrolled human fertility."

Whether one is primarily interested in world peace, fighting communism's spread, raising living standards, improving community or family life, or increasing the individual's opportunities for development and increased happiness and better health, these worthy goals can only be realized in conjunction with fertility control and responsible and voluntary parenthood.

Mankind's existence is threatened not only by atomic warfare. Famine on a tremendous scale involving hundreds of millions of people has been predicted for the 1970's by responsible scientists. This is in spite of the optimistic views of some that the earth can feed ten or more billions if we eat plankton three times a day—a rather dismal outlook! The Food and Agriculture Committee of the United Nations reported that merely to keep conditions from becoming worse, and some say 80% of the world's population are chronically hungry, the world food output would have to be doubled by 1980 and tripled by the year 2000. The same committee said recently that while food production has been markedly increased, populations had increased more rapidly so that every year successively for the last five years there has been less food for each person in the world than there had been the year before. This is another reason why the National Academy of Sciences warns us that "either the birth rate of the world must go down or the death rate must go back up." Which shall it be?

What about the United States? Obviously the world has a quantitative population problem of tremendous proportions. Do we also have one, or is ours more qualitative in nature? At present the problem in this country is more qualitative, but there is no cause for complacency as far as the quantitative aspects are concerned. Our population may also double by the year 2000 so that we might approach 400 million. This number might be accommodated if they were spread over the countryside. One difficulty is that today 75% of our people live in cities. This trend is not likely to be reversed, so our cities will become bigger and bigger, with more and more spilling out into suburbia. Three thousand acres a day of good topsoil are being bulldozed away to make room for shopping centers, housing developments, and highways. The statisticians tell us that we need two and a half acres of land for each person if we are to enjoy our present standard of living. We need this land to grow food, to raise cattle, sheep, pigs, chickens, and to grow timber for our economy. New York City alone, with a population of eight million, would then need 20 million acres of land to support it.

As our population grows and grows can we solve the problems of transportation, education, employment, recreation and maintain a way of life that will make living worthwhile? Why have we not yet outgrown the notion that a growing population and a booming birth rate is synonymous with a booming economy? More numbers do not assure high living standards. Look at India and China! And the businessman ought to realize it is the buying power of the individual and the family that keeps the economy healthy. We could probably be happier and more prosperous with a population stabilized at 200 million than with one at 400 million. In 150 years, the US may have three billion. So we do have a potential quantitative population problem, one which may become increasingly serious in the future.

Most of our present difficulties in this area stem from the fact that those least qualified for responsible parenthood are having the most children. Being "underprivileged" or "disadvantaged" or whatever one wishes to call it seems to encourage larger families than are found in the more "fortunate" segment of society. Statistics for New York can be used to illustrate. There are about 500,000 people in New York living on the

Welfare and under substandard conditions. They represent one-sixteenth of the population, yet they are producing one half of all the babies born in the city. They cost the tax payers about $500 million a year in direct relief handouts, and the services of 12,000 social workers are needed to distribute the checks.

The social costs are not measured in dollars and cents, but they are probably much higher than the tax bill. How many of the babies born in Welfare families are wanted? How many are loved? How many are rejected, neglected, and even abused? What about the 10,000 children a year who make up the "battered child syndrome"? What are the death rates, the disease incidence, the percentage of illegitimates, the number of alcoholics, drug addicts, the crime and juvenile delinquency rates in these "poverty pockets"? How many children, this half of New York's baby crop, will be able to fight their way out of the jungle and contribute to society and make useful and happy lives for themselves? Or will the Welfare become the only way of life they will ever know and continue to the third and fourth generation?

What of their mental health? Dr. Karl Menninger says: "Nothing is more tragic, more fateful, than the realization by a child that he is not wanted: From a purely scientific point of view, planned parenthood is essential in any program for increased mental health and for human peace and happiness." Other psychiatrists think that parental rejection in childhood will contribute to a deep resentment against society which may flare out into delinquency and crime.

Public Attitudes Toward Birth Control

Changes in attitudes regarding birth control have been taking place slowly for many years. Margaret Sangers no longer go to jail for trying to help the underprivileged to control their fertility. Progress has been rapid in the past few years, perhaps as a part of the sexual revolution of modern times. In 1960, 72% of Americans were in favor of making birth control available to anyone who wanted it. In 1964, the figure was 74%, and in the spring of 1965, a Gallup poll showed that 81%, or eight of every 10 people interviewed, favored free access to birth control.

There has been a tremendous increase in magazine articles and radio and television programs dealing with the many aspects of fertility control, from the population explosion to abortion and sterilization. Nearly all have been progressive and in favor of voluntary and responsible parenthood.

Today we can say that the people of the United States cannot be held responsible for the anachronistic attitudes and policies of many branches of our government when it comes to birth control nor for the ultraconservative attitudes of so many members of the medical and legal professions. The people want constructive action in this field.

Governmental Attitudes

In 1959, the Draper report recommended that the United States should help underdeveloped nations control their exploding populations, if asked to do so, as part of our foreign aid program. President Eisenhower emphatically rejected this suggestion, saying he could not think of anything less suitable for our government to undertake. I understand he has subsequently changed his mind.

President Kennedy felt that the United States should neither encourage nor oppose birth control in other countries but should be willing to consider any request for help.

Under President Johnson, our federal policies have progressed from the disapproval of Eisenhower, through the rather passive acceptance by Kennedy, to actual promotion. In several speeches, President Johnson has expressed his concern about the population problem and his desire to do something about it. The Children's Bureau, a unit of the Department of Health, Education and Welfare, has allotted $5,500,000 to support birth control clinics in certain cities where birth control advice and supplies are given. In 1964, Congress appropriated $25,000 to set up birth control clinics for the indigent in Washington, DC, and this year the sum has been increased to $200,000.

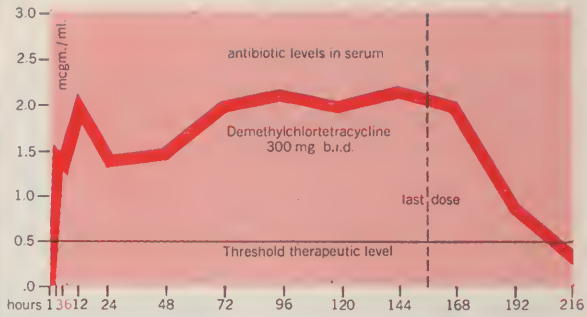
The Office of Economic Opportunity, under Sargeant Shriver, has approved all methods of fertility control for the indigent except the surgical method of voluntary sterilization, as part of the war against poverty. Since the most effective single weapon in this war against poverty is fertility control, it is unfortunate and regrettable that Mr. Shriver excluded one of the most effective methods of family planning; 100,000 more



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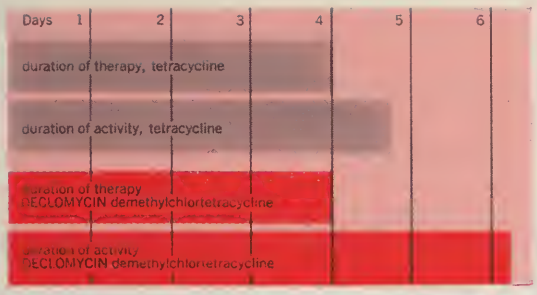


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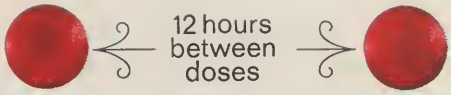
From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962





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Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

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privileged Americans choose this method every year. Methods and techniques should be left to be decided between the patient and the doctor concerned and should not be dictated by the head of OEO.

Medical Attitudes

Has the medical profession kept up with the progress made by the people and the government? Unfortunately, no! There has been some progress, however. A former president of the American Academy of General Practice, who had also been the president of a State Medical Society, said, not many years ago: "Physicians are in practice for only one reason: to treat sick people." Such dedication to one line of endeavor tends to remove the doctor from the world and its woes. Are we medical men not concerned with such things as the possible annihilation of mankind or the destruction of our civilization? Should we remain aloof to the problems that will confront us as the recipients of the Welfare continue to outbreed those who support them? As we go about healing the sick, or adding to the population, might we not worry at times about the type of life our children and grandchildren will have? Our communities may be sick with delinquency, crime, poverty, unemployment, substandard education, discrimination in various forms, and political corruption. Are not these plagues as worthy of our attention as the old ones of typhoid, smallpox, diphtheria, or polio? They may be more so since diseases merely kill individuals, while the new plagues may destroy our ideals and way of life.

Albert Einstein has placed the blame for many of the most serious problems facing mankind squarely in the lap of the medical profession. He said: "Progress in hygiene and medicine has completely altered the previous precarious equilibrium of the quantitative stability of the human race. I am, therefore, firmly convinced that a powerful attempt to solve this tremendous problem is of urgent necessity." We of the medical profession have been so successful in lowering death rates while ignoring the other half of the balance that we have hopelessly upset the natural equilibrium. Only we can restore the needed balance, yet even now we spend 500 times as much on research into better methods of death control than we do in better methods of birth control.

After years of silence and avoiding the issue, the AMA in December, 1964, issued a statement of policy regarding birth control, or family planning. They said that family planning was not only part of responsible parenthood but was also part of responsible medical practice. Doctors are obligated to supply birth control services to patients who wish it or, if the doctor does not care to do so, he should refer the patient to some suitable person or agency. He ought not to impose his own views or disapproval on the patient, as has so often been done individually and collectively. The AMA policy goes on to say that birth control should be made available to all who need it, "whether they obtain their medical care through private physicians or tax or community supported health services."

This recent statement of policy, along with the lifting of legal and governmental restrictions, should be all that is needed for doctors, hospitals, and public health and welfare departments all over the United States to really forge ahead toward the goal of having every baby come into the world because it is wanted and when it is wanted by its parents.

North Carolina has gone far along this road. Every county offers the indigent family planning advice and supplies. Tax funds are used to pay hospitals at the rate of $20 a day for women welfare recipients who elect to terminate their fertility by sterilization in *all* counties. In four counties, tax funds are also used through the Welfare Department to pay the operating surgeons $50 for the procedure. Two counties in Virginia and two in Michigan have similar arrangements: yet, in many parts of the country, citizens, doctors, and lawyers mistakenly believe such things cannot be done.

The time has come, as Dr. John Rock says in his book, not only for Catholic and non-Catholic to work together for voluntary and responsible parenthood, with suitable compromises as to methods to be used, but for the medical profession to recognize the seriousness of the population problems at home and abroad and to take its rightful place as leaders in this great and urgent effort. What good will a cancer cure and men on the moon do if the world succumbs to overpopulation?

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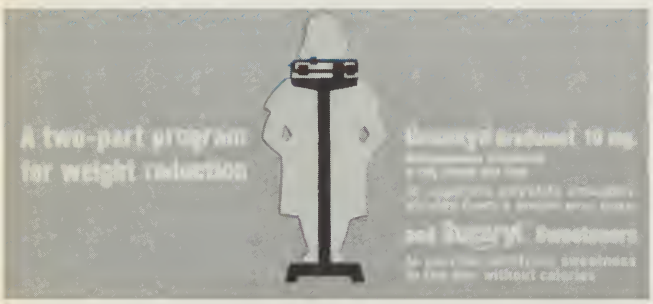
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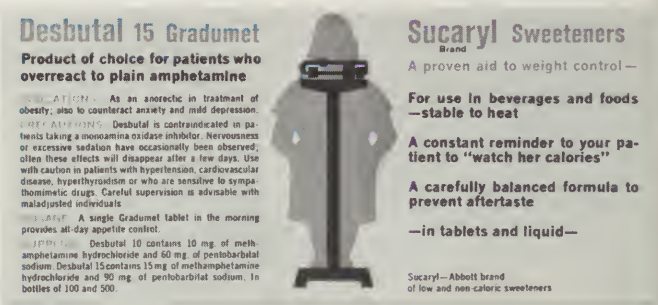
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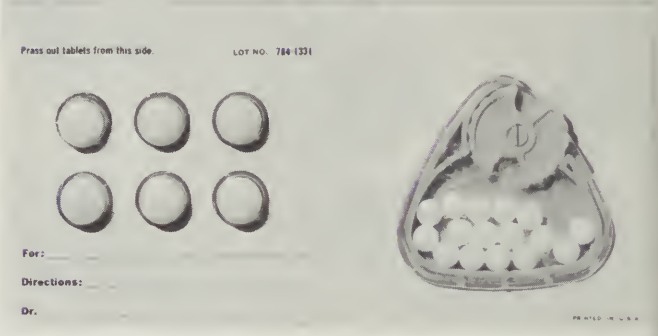
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FAMILIES AND PHYSICIANS

The story of a half-century of medical progress in a typical American community—Damascus, USA, is a tribute to a distinguished physician whose devotion to and care of the sick remain a warm memory in the minds of many families.

JOHN PARKS, MD
The George Washington University School of Medicine

It is indeed an honor to present this lecture in memory of Dr. George M. Boyer, a distinguished alumnus of The George Washington University School of Medicine and a physician whose devotion to the care of the sick remains a lasting memory in the minds of colleagues, families, and friends of Damascus and Maryland.

After careful planning, a hospital was built in Damascus. It contained pavilions for men and women. "There were separate wards for internal medicine, surgery, orthopedics, and eye diseases. A large pharmacy well stocked with drugs was attached to the hospital. Patients who did not need hospitalization were given prescriptions that they had filled at the pharmacy. In a spacious hall was a library containing most of the available medical manuscripts." The physician in charge made the rounds of the patients, found out their condition, and considered their affairs. He had "with him assistants and orderlies, and all that he wrote down in the way of orders for each patient regarding medication and care was carried out carefully. After finishing his rounds he used to go up to the citadel and treat whoever was sick among the nobility and the government officials. Then he would come back to the hospital . . . to teach the students and discuss the medical topics and difficult cases with the physicians."[1] This was the Nuri Hospital of Damascus, Syria, around the twelfth century. It served as a model for other hospitals of the period in Syria and Egypt. Specialization prevailed.

George M. Boyer, MD, Fund Lecture, presented at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 27, 1966.

As early as the fifth century, BC, Herodotus wrote: "Each physician applies himself to one disease only, and not more. All places abound in physicians; some physicians are for the eyes, others for the head, others for the teeth, others for the intestines, and others for internal disorders."[2]

"There is no new thing under the sun."[3]

In our country, early in the nineteenth century, there was a small cluster of houses located on what land grant records of the State of Maryland described as the "Pleasant Plains of Damascus"; and there five generations of the Boyer family have lived.

After an early academic career that included graduation from Shenandoah College, four years as a teacher, and then a medical degree from The George Washington University School of Medicine in 1902, Dr. George M. Boyer returned to Damascus, where he served as family physician in this Maryland community for more than a half century, until his death in 1956, at age 84.

Doctor Boyer was a highly respected, warmly appreciated physician. He loved people and was tireless in his efforts to help them. During his 50 years in practice, he made his rounds on horseback, motorcycle, and automobile; he delivered more than 3,000 babies, almost all of them at home, usually with the aid of a practical or trained nurse. He saw 90% of his patients in their homes and only about 10% in his office. Similar to many physicians of his time, he never bothered about bills. Medicine, like the ministry, was a calling, and finances seemed the least important part of it.

When World War I broke out, Dr. Boyer was 45 and had four children, but he enlisted and soon rose to the rank of major. After the war Dr. Boyer rushed home to help fight a serious epidemic of influenza that had brought death to neighboring physicians and townspeople.

In Dr. Boyer's day, rural and small town homes consisted of relatively large houses containing big families. A visit to see one ailing member usually resulted in at least a verbal summarization of the health of the whole family. The family doctor dispensed more than pills, powders, and poultices. He carried with him a reassuring pharmaceutical aroma that became evident before he reached for the pulse, felt the forehead, or opened his well-stocked black bag. His quiet identification was as impressive as his verbal communications.[4] He often served as family confessor and adviser, taking the total life of his patients in daily stride.

Doctor Boyer read diligently from medical journals, attended medical meetings, and served as president of the Montgomery County Medical Society. He kept current with the scientific advances of his day and attended his patients with a compassion that was truly inspiring. This image of the family physician should never pass into medical oblivion. These wonderful qualities of empathy, understanding, and compassion, that we have long called the art of medicine, still have their important part to play in the practice of medicine. They can be provided for patients equally as well by specialists as by generalists. The science and techniques of medicine never need be cold. They can be delivered with warmth.

I am reminded of an anesthetist on our staff, a highly skilled individual, who was treating a patient with agonizing nerve root pain caused by cancer. After warm and friendly greetings and while making proper preparations for an intrathecal injection, he began to hum an aria from a favorite opera. By the time he had completed the injection procedure, his patient had joined in the chorus, and she left the operating room in a relieved mood quite in contrast to her entry.

Let us now turn our attention to Dr. M. McKendree Boyer, past president of this distinguished Faculty,[5] for a modern profile of practice in Damascus, USA: an example of American medicine at its best.

Like his father, Dr. McKendree Boyer received his medical degree from The George Washington University. He continued his education with an internship followed by residency training in internal medicine at the St. Luke's Hospital in Cleveland and by postgraduate work in London and Vienna. He returned to Damascus to work with his father.

Three decades have changed Damascus. It is no longer rural. Little farming is done in the area. Damascus has become a community made up almost entirely of commuters. Doctor McKendree Boyer's practice is conducted in a well-equipped medical building designed to blend into the neighborhood. The present Boyer Medical Building is like a small hospital with offices for three physicians and a complete set-up for a dentist. A laboratory, diagnostic x-ray and cardiographic

equipment, nurses' station, and waiting rooms for children and adults complete the facility. Many more patients can be seen and more efficient care can be given in this office—open days and evenings—than was possible a generation ago when home calls were a major part of practice. Dr. Boyer has continued his specialty of internal medicine and believes that an associated group practice is the best way to provide families with the medical care they need. Let us consider this thought in terms of our present and future responsibilities as physicians.

Americans of the past half century have been on the move. In a population of almost 92 million in 1910, 18.4% moved each year; whereas, in 1964, 19.6% of 194 million people changed residence at least once during a single year.[6] Young people in their reproductive, working years move to the suburbs, while older people tend to move to cities from outlying areas. In some city areas today more than half of these older people live alone.[7] For a large part of the populace, apartment-dwelling has replaced home environments that were surrounded with yards and trees. Thus, as physicians, we have a responsibility to a constantly changing, ever increasing group of patients, the majority of whom report only for episodic care.

In turn, families moving to new communities have difficulty finding medical security among the widely diversified and physically separated specialists. Sympathetic specialists are frequently called upon to serve as family advisers and physicians far from their field of medicine. It is not at all unusual for a family to have a list of half a dozen or more doctors to call for individual illnesses. Selection of the right specialist depends first upon self-diagnosis. In this regard, the mothers of our country practice the medicine. They make preliminary diagnoses and decisions, call the doctor, and carry out the bedside treatment. They give birth to the children, nourish and protect them through a period of dependency, and guide them through adolescence to marriage, parenthood, and a new family that is usually established apart from the parent home, frequently at a great distance from the original environment.

How much easier it would be for families to have reliable medical clinics or centers to which they could report for complete medical care, and how much more effective physicians are when they combine their professional resources. Shared office overhead also increases the individual earnings of doctors.

Patients have become accustomed to going to the doctor, but they want these diagnostic and therapeutic services near their homes. In communities where there are hospitals, physicians are finding it increasingly convenient to establish offices nearby. Traveling from home to office to hospital and from hospital to hospital has become as time consuming for the specialist as home calls were for the practitioners. The doctor's time has become too valuable to spend it in traffic during the most productive part of his day.

The physician must make effective use of his office hours. Many more people are demanding his services. In 1930, 44% of all patient visits were in the home; in 1960, only one visit in 10 was in the home. In 1931, the average number of patient visits per physician per week was 50; today the number is twice that many.[8] In order to meet the increasing needs of his patients most effectively, the physician must develop and use ancillary medical personnel and new methods in his office, just as in the hospital. Laboratory data and patient records should be transferred readily and completely from office to hospital and back from hospital to office so that continuity of care is maintained and costly reduplication of services is avoided. As captain of the health team, a significant part of the physician's success depends upon his ability to coordinate his services with those of his co-workers. Where patients can come to a central source for their health needs—a single stop service—whether it be a small group practice clinic, a community office-hospital facility, or a large, specialized city medical center, services in these settings can be provided more effectively and efficiently than in widely separated specialty offices.

Hospitals

Hospital resources in our country have increased more rapidly than the population. Community and Hill-Burton funds have brought hospital facilities to hamlets, towns, and suburban developments throughout the land. Doctor Luther Terry has reported that in the past 30 years there has been an increase from 3.7 to 4.6 general hospital beds per 1,000 population. But during this same period of time, hospital admission rates have increased from 56 to 132 per thousand

people per year, and the average hospital stay has gone up 47%.[9]

Overcrowding and understaffing of hospitals is a prevalent problem throughout the country. Hospitals have become so accepted and convenient for the care of all medical problems that lack of a hospital bed has become a hazard for the acutely ill individual, as well as a time-consuming concern of the patient's physician. At the hospital, the physician orders services while he is neither producer nor consumer. He is only privileged to work there, provided space and time are available for him to carry out his services for those patients who can be admitted to the hospital.

As Ray Brown has stated, "Scientific medicine changed the hospital's purpose from one of congregating patients to one of congregating resources. By the same token, it changed the hospital's responsibility from a limited one of congregated care to an unlimited one of comprehensive care."[10] Nowhere is this more true than in the emergency units of modern hospitals. Emergency facilities have become more than accident wards. They now serve as important community health centers. After dark, on weekends, and during holidays, an increasing percentage of the population turns to the nearest hospital for relief of bodily discomfort or mental anguish. Emergency facilities are crowded with a cross section of the citizenry seeking medical or surgical aid for assorted ills. No appointment is needed. Physicians and nurses are always on duty, and regardless of the patient's illness, the emergency room physician must first serve as a diagnostician and then possibly as a specialist.[11]

In terms of time, patients 25 miles from the nearest physician or hospital are closer today than were our ancestors living three miles from the doctor.[12] But with crowded highways and congested city traffic, recent experience has shown that helicopter ambulance service to a hospital is a quicker life-saving procedure, in many instances, than other forms of emergency transportation.[13]

Community hospitals were never intended to provide all the specialty procedures that can be accomplished in university medical centers. They should serve as satellites of the large medical centers. Patients are happier when they can be near their home and depend on their physician to tell them when their problems are too complicated for the community hospital.

It has been determined that in an average month, out of an adult population of 1,000, 750 will experience an episode of illness, 250 of these will consult a physician, nine will be hospitalized, five will be referred to another physician, and only one will be referred to a university medical center.[14]

These few special, referred patients who can pay for care receive excellent treatment at university centers. Semi-indigent patients, who make up the major rolls of teaching hospital outpatient departments, receive attention in increasing proportion to the complexities of their problems. Theirs is the long registration line, the hard bench, the meticulous and detailed history, the waiting period for a staff checkover, and the short period of therapeutic instruction. Outpatient departments, rather than serving as office examples for the house staff, frequently represent patient selection areas for hospitalization of interesting pathologic conditions. The patient's total needs may be lost in the finding of an unusual heart murmur that deserves special studies.

In this setting, Knowles has stated, "A two-class system of care has prevailed whether it be the contrast between inpatient and outpatient or private versus clinic patient."[15] Is this the best care university centers can provide separate segments of society, and is this the best teaching that can be accomplished with ambulatory patients? This system of clinical instruction is deeply ingrained, but it can and should be improved. For example, appointment times could reduce waiting time. We need to reevaluate clinic and home care in terms of the total population and with regard to the responsibilities of our future physicians.

Medical Education

The basic science faculties, fully engrossed in useful investigative activities, no longer need to teach dull, empiric principles; they have a vital new molecular biology that is based upon valid experimental findings. Basic science teaching and research have a profound meaning for every patient as well as for all students of science.

Possibly medical educators have been working with a clinical population sample that is too highly selected. Clinical faculties in medical schools

have become highly departmentalized and specialized; they provide their students and health staff with excellent scientific experience in horizontal, episodic, and unusual medicine. Exposure to a super-selected sampling of illness alone provides an unrealistic concept of comprehensive medical responsibilities. Several schools of medicine have started, and others are sure to follow, with programs of comprehensive medical care. Some of these programs of vertical medical education introduce the student to the total health needs of individuals in the community by preceptor experience with practicing physicians. At other schools, attempts at teaching vertical clinical medicine have been made through comprehensive care clinics. At our school, experiments in comprehensive care have been practiced for more than 10 years, but much more intensive evaluation of the science of health service as it relates to undergraduate and postgraduate medical education is long overdue in all clinical centers.

Working in complete cooperation with community hospitals, professional staffs, and medical societies, university programs in medical education must extend well beyond the campus to serve as a ready resource for the exchange and advancement of useful thoughts. As Fox recently said, "In human evolution we have reached a point where further progress can come only from thinking. And thoughts can come only from minds—the minds of individuals."[16]

It seems to be a common misconception of graduates of medicine that the professor thinks he has all the right answers. The professor who is a true teacher takes more pride in the independent thoughts of his students than in his own authority. Medical educators and medical practitioners must come closer together. There is no room for delusions of accuracy. In our individual professional responsibilities everyone must be accurate, ethical, effective, and progressive. Practices must keep current with the preciseness of science. The practicing physician is a translator and transmitter of scientific progress from the laboratory bench to the patient's bedside.

All of us gathered here today know about and have benefited from the phenomenal advances of medical science of the past half century. Sanitation, vaccination, immunization, chemotherapeutic and antimicrobial agents have changed man's way of life. In turn, these advances have produced a profound disruption of the biological balances of nature.[17] We must assume full responsibility for the drugs, appliances, and surgical procedures we use. Drug dangers must be balanced against drug benefits. No drug or fluid or operation is totally innocuous.

In addition to learning how to use intelligently and benefically a constant myriad of new drugs and instruments, physicians must apply their interests and talents beyond the individual desires of patients to the necessities of world population control. Medicine must help prevent new life in order to have time and resources to care for those about to be born or who are already living. Population increases disproportionate to deaths are rapidly crowding a world in which modern travel and communication have made us all global neighbors. No disease is so remote that it cannot be transferred to any part of the earth in less than a day. In this setting, it is essential that each of us maintains a responsibility for the world of medicine in which we live.

Technology has become a part of medicine too, but automation cannot assume responsibility. Computers are rapidly assuming medical status, but patients will always be grateful to have a human at the controls. We can make a plastic filler for the brain or breast, a glass jaw, a pliofilm aorta, or an artificial limb. These are superficial, artificial, and beneficial patient parts, but when attached they are something of the patient—a troubled human who needs additional help. We cannot manufacture the mind or substitute the spirit of life.

"Today, when so many progressive minds are preoccupied with ways of doing things," Fox has said, "we too easily forget what ends these means are meant to serve. If doctors were scientists they might, like scientists, disclaim responsibility for the uses to which their knowledge is put. But medicine is not itself a science; it is a form of service which is as much concerned with ends as it is with means. The doctor has to make sure that what he learns is used to help rather than to hurt."[18] The teacher of medicine —and all doctors are teachers—must apply this service measure of medicine to his daily work.

Society and the Profession

Ralph Waldo Emerson has said, "The first wealth is health." Health is an individual's greatest possession and a nation's greatest strength.

The rich cannot buy health; the poor have not been able to afford it. Health, like education and natural resources, is a shared asset of an advancing civilization. In our country, care of the indigent has been a thing apart from private practice, but soon medical indigency will be a thing of the past.

The American public has gone on record by clearly expressing, through the 89th Congress, that health care is as fundamental to human life as is education. More than a dozen health-related bills were passed by the 89th Congress, and implementation of these public laws is well under way. Through an elaborate partnership between Social Security and private third party insurance agencies, the elderly, the handicapped, and needy individuals under 21 years of age will be eligible for health insurance benefits never before available to them. Within less than a decade it is anticipated that every American citizen will have the privilege of selecting his own private physician or clinic.

Society has singled out the older people for a reason. They have more illnesses and fewer fluid resources; they are increasing rapidly in number; they have limited opportunity for gainful or purposeful employment, and they present unmeasurable problems in social and psychiatric as well as physical and rehabilitative care. Society must meet the problem of aging with more than money and medicines, hospitals and nursing homes. Methods of keeping these older individuals usefully integrated into the mainstream of life, in homes of their own that are suited to their limited physical reserves will preserve self-esteem. Loss of self-esteem is the first step to mental disability. Physicians are going to have responsibility for an increasing number of people 65 or older, of whom 80% have a chronic ailment; 28% have arthritis or rheumatism, 17% have hearing impairment, and 10% cannot see as well as they should.[19]

Only half the nation's population, estimated to reach 235 million by 1975, will be between the ages of 21 and 65. The very young and the aged are the two groups requiring the most in medical services.[20] They are the ones to whom preventive and health preservative measures are highly important.

I can speak with some experience about the benefits of periodic health examinations for elderly women. Since the cervix, uterus, ovaries, and tubes are in the hidden recesses of the body cavity, women are handicapped. They have no way of seeing their reproductive structures. They depend entirely upon their physician for early diagnosis of internal genital disease. Periodic health examinations, including careful pelvic examination, cytologic smears, endometrial aspiration, and indicated biopsies, are our only current means of finding early genital cancer in women in the curative stages of the disease. The incidence of all types of genital cancer increases after the age of 50.

Some physicians allocate a half day or more of their office time to these periodic health examinations of well women. Such an office morning can be one in which there is no rush resulting from a backlog of waiting, sick patients. Many healthy women hesitate to go to the busy doctor when they know that there are other patients with real illnesses who need immediate attention. They are apologetic about taking up the doctor's time, and, if by word or by action the physician or nurse makes the patient feel like an unwelcome neurotic, she will not return. But these well-educated, older women are only a small segment of the population. Aware of the importance of their health, they are capable of finding their way in our medical world.

Others are not so intelligent or so adequately financed. From years of municipal hospital experience, I know, too, about the complications of the unregistered expectant mother, the frightened patient who harbors a tremendous genital tumor until is is more than apparent, and the superinfected person who reports to the emergency room next to death's door. These represent gynecologic samples of an inadequately treated populace. They present a challenge to medical science, but more importantly they represent an educational and therapeutic responsibility that must be shared by society, by medicine, and by science.

Social inertia and emotional immaturity are part of the culture of every nation, and in these areas all countries show varying degrees of underdevelopment. Poverty, illness, and illiteracy form a fomenting triad in which one part adds to the other. American medicine's biggest challenge and greatest opportunity of the next decade is its open invitation to join social and economic forces to combat diseases and disabilities of the economically, socially, and physically handicapped members of our society while maintaining

the health and stability of those who make up the productive working manpower and the protective military forces of our nation.

The larger and more compact the urban area, the greater seems to be the need for non-patient financed medical care. For example, in New York City, it is estimated that one-half the hospital bills and one-third of the entire medical care costs of illness are currently being borne by governmental programs.[21]

Governmental medicine is not new. Only the method of sharing costs and producing a wider distribution of better services is new. Every physician in this room has given freely of his time and talents to care for the indigent ill. The ward patient usually was a responsive individual, and it gave us a good feeling to give of our services without thought of remuneration. The teacher always gains as he gives. We explained the difference in health statistics between the ward and private patients on such factors as race, economic status, social habits, or the inexperience of the house staff. This latter implication always bothered me. I have always thought house staff doctors about the best ones to have when you are really sick.

Perhaps the threat of having no free patients strikes at our sincerely altruistic medical consciences. Being paid for the care rendered to every patient is a new concept for many of us. In our country we think of life as priceless, and it is well within the capabilities of physicians to preserve life. But it is still difficult for doctors to place a cost value on services. Is a surgeon's high fee as justifiable as a low fee for an equally life-preserving injection of adrenalin? Economic accounting cannot be settled on life alone. As a profession we have shown variable abilities to place a proper price on our services even for those capable of paying. This has led the public, business organizations, trade unions, and government to demand of medicine such economic procedures as prepaid health programs, insurance limitations, and relative value scales.

As physicians we are experiencing an increasing participation of lay people in medical affairs. Medicine, like the military, has become too important to be left to the professionals, and, too, health care has become big business. Approximately 6% of our 600 billion gross national product is spent on health. Ours is a commercial culture, as advanced in the art of production, trade, communication, and profit as has ever been developed in the history of man; and almost everything that influences individual actions seems to have a dollar value.

To meet new dimensions of medical care, physicians, medical schools, hospitals, all members of the health professions, and community leaders need to consider carefully past procedures and present practices with a view of developing ways and means of providing comprehensive medical services for all the people. Barriers and biases have no place in medicine. In the fellowship of healing, any human being anywhere in need of medical care deserves a helping hand, a thinking mind, and the best there is available to meet the health requirements of the individual and his family.

901 23rd Street NW
Washington, DC 20037

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A Key Site of Action of the Protoveratrine A in Salutensin

"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



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In mild to moderate hypertension:

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Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

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BRISTOL THERAPEUTIC SUMMARY
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Indications: Essential hypertension.

Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.

Contraindications: Salutensin is contraindicated in severe depression.

Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).

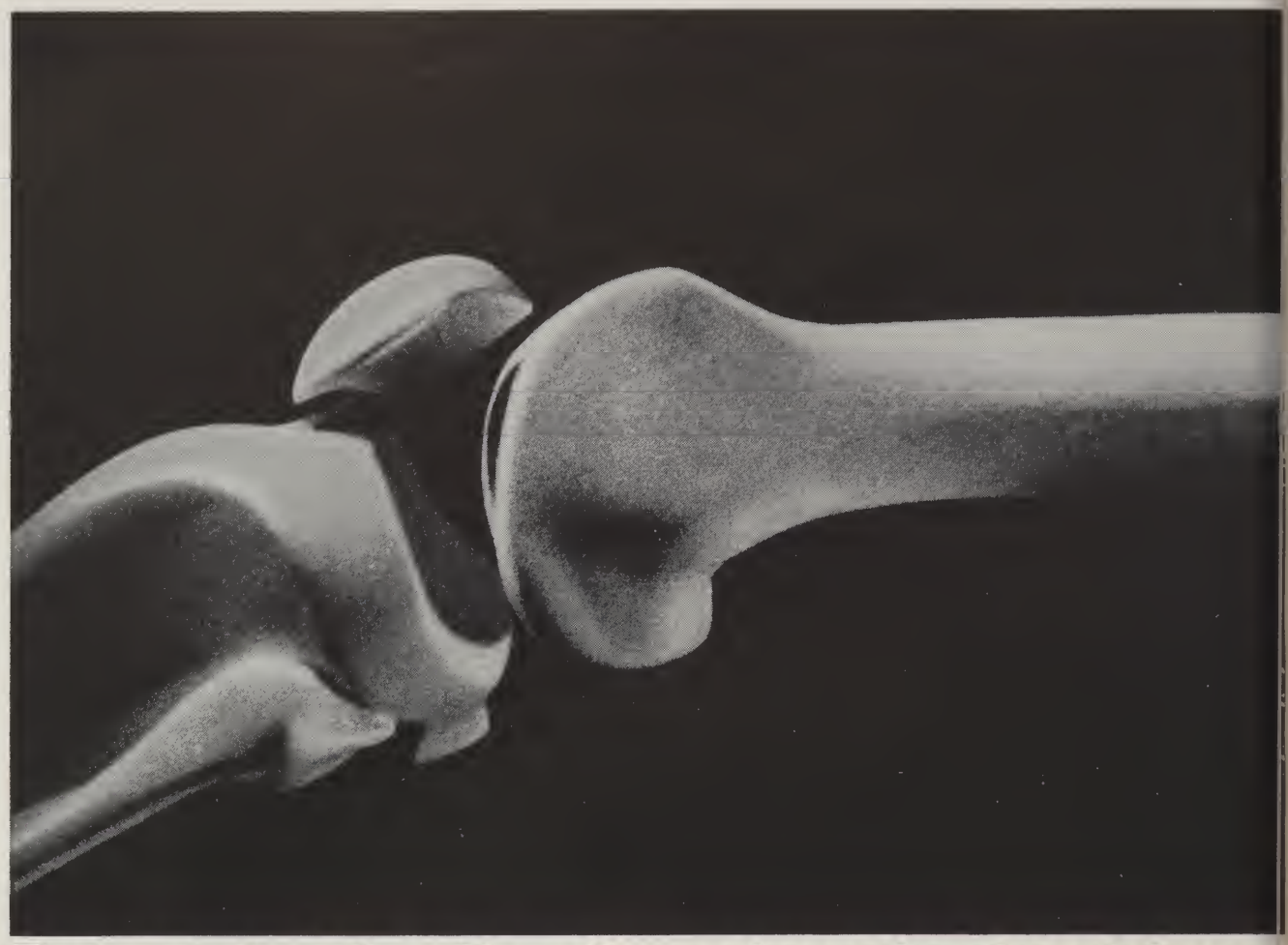
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)

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Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria a hematuria. With long-term use, reversib thyroid hyperplasia may occur infreque

Dosage
The initial daily dosage in adults is 300-4 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. Whe improvement occurs, dosage should be creased to the minimum effective level: s should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. da

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BUSINESS SESSIONS

SPECIAL MEETING
January 29, 1966

MINUTES

The 252nd meeting, Special Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 2:05 P.M. Saturday, January 29, 1966, at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. An asterisk indicates an alternate delegate.

Doctors: John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; Harry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; M. McKendree Boyer, Past-President; Robert vL. Campbell, President; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katharine A. Chapman, Montgomery County; Henry V. Chase, Council; Archie R. Cohen, Washington County; H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Baltimore City; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore City; *Robert Dawson, Allegany County; John B. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; J. Sheldon Eastland, Past-President; William C. Ebeling, Council; Emanuel S. Ellison, Baltimore City; *Max R. English, Baltimore City; James McC. Finney, Harford County; Whitmer B. Firor, Past-President; Russell S. Fisher, Council; *Harold H. Gist, Washington County; Albert E. Goldstein, Past-President; *Paul F. Guerin, Baltimore City; William B. Hagan, Council; Thurston Harrison, Council; John C. Harvey, Baltimore City; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; James P. Jarboe, St. Mary's County; James R. Karns, Baltimore City; *Arthur T. Keefe, Kent County; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Howard F. Kinnamon, Past-President; Louis Krause, Council; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; Norman Levin, Baltimore City; *Eugene J. Linberg, Baltimore City; F. Ford Loker, Baltimore City; William J. McClafferty, Baltimore City; George S. Malouf, Prince George's County; Karl F. Mech, Council; Philip W. Mercer, Carroll County; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald Mintzer, Baltimore City; Andrew C. Mitchell, Wicomico County; Frank K. Morris, Board of Medical Examiners; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Past-President; William A. Pillsbury, Council; *Samuel R. Pines, Baltimore City; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas Reid, Frederick County; Paul F. Richardson, Jr., Council; *John O. Robben, Montgomery County; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; Edwin Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; *George W. Settle, Anne Arundel County; Thaddeus C. Siwinski, Baltimore County; R. Kennedy Skipton, Prince George's County; John N. Snyder, Baltimore County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Aaron H. Traum, Montgomery County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson Walden, Baltimore City; Hugh W. Ward, Calvert County; J. Arthur Weinberg, Council; *Ralph H. Williams, Washington County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; *Arthur F. Woodward, Montgomery County; *Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Staff personnel were also present for the meeting.

The President made certain announcements with regard to the conduct of business at the session.

PRESS EXCLUDED

On motion of Dr. Settle, the press was excluded from the session.

RESOLUTION ADOPTED

Dr. Settle, chairman of the Professional Fee Fund Committee, reported on its behalf and offered the following resolution which, after debate and amendment, was adopted as follows:

Resolved, That a Committee consisting of sixteen members be established under the Bylaws consisting of a chairman and a representative from each of the following organized specialty groups in the State:

Maryland Society of Internal Medicine
Maryland Radiological Society
Maryland Chapter, American Academy of General Practice
Maryland Orthopedic Society
Maryland Pediatric Society
Maryland Ear, Nose and Throat Society
Maryland Society of Pathologists
Maryland Thoracic Surgical Society
Obstetrical and Gynecological Society of Maryland
Maryland Ophthalmological Society
Maryland Society of Anesthesiologists
Maryland Chapter, Industrial Medical Association
Maryland Chapter, American College of Surgeons (General Surgery)
Maryland Psychiatric Society and
Maryland Dermatological Society

Resolved, That the Committee thus established be appointed immediately and have as its purpose rendering assistance to those who have requested it in clarifying specific contractual arrangements which they have, rendering assistance to those who request it in negotiating ethical contracts and that appropriate changes in the Bylaws be made to effect this.

RECESS TAKEN

Dr. O'Donnell, on behalf of the Bylaws Committee, moved the adoption of amendments to the Bylaws in accordance with the notice which had been sent as provided in the Bylaws by amending Article X by inserting

a new Section 20 and by amending Article XIII by substituting for it a new Article XIII. Dr. O'Donnell then offered substitutes for these amendments. The meeting thereupon, by unanimous consent, recessed for ten minutes.

BYLAW AMENDMENTS

Upon the expiration of the recess, the proposed substitutes for the Bylaw amendments were considered seriatim and, after debate and amendment, the proposed substitutes for the Bylaw amendments were divided to be voted on separately, and the Bylaw amendments, as thus amended, were then adopted on division votes by more than the required two-thirds. The Washington County delegates asked that the minutes reflect that it voted against the amendments as instructed by its Society.

To amend Article X by inserting after Section 19 the following Section 20 (all succeeding Sections being automatically renumbered):

Section 20. As soon as practicable after the annual session each year a Committee on Contractual Arrangements shall be appointed whose purposes it shall be (a) to render assistance to those members who request it in clarifying the ethical standards applicable to specific contractual arrangements they have, and (b) to assist those members who request support in negotiating ethical contracts. The committee shall be appointed by the Faculty's President and be composed of a chairman and one member selected from and nominated by each of the following specialty groups: Maryland Society of Internal Medicine; Maryland Radiological Society; Maryland Chapter, American Academy of General Practice; Maryland Orthopedic Society; Maryland Pediatric Society; Maryland Ear, Nose and Throat Society; Maryland Society of Pathologists; Maryland Thoracic Surgical Society; Obstetrical and Gynecological Society of Maryland; Maryland Ophthalmological Society; Maryland Society of Anesthesiologists; Maryland Chapter, American College of Surgeons; Maryland Psychiatric Society; Maryland Dermatological Society; and Maryland Chapter, Industrial Medical Association. All members of the Committee shall be members of the Faculty. Should any specialty group fail to submit a nomination within sixty days from the date requested to do so, the President may appoint any member of the specialty group to fill the vacancy. Nine members of the committee shall constitute a quorum.

To amend Article XIII of the Bylaws by substituting for it the following new Article XIII:

Article XIII—Disciplinary Procedures

Section 1. The "Principles of Medical Ethics" of the American Medical Association are adopted as the ethical standards of the Medical and Chirurgical Faculty of the State of Maryland and shall govern the conduct of members in their relations to each other and the public.

Section 2. The judicial powers of the Faculty, other than that vested in the Mediation Committee, shall be vested in the Executive Committee of the Council whose decision shall be final.

Section 3. Except as otherwise provided in these Bylaws the Executive Committee of the Council shall have jurisdiction on (a) all questions involving membership; (b) all controversies arising under these Bylaws and the principles of medical ethics of the American Medical Association and the Faculty; and (c) controversies between two or more component societies or their members. In addition, the Executive Committee of the Council shall have original jurisdiction where a county society to which a member belongs requests the Faculty to take disciplinary action or, when at the request of the Faculty, the county society to which the member belongs consents to disciplinary proceedings by the Faculty.

Section 4. The Executive Committee of the Council shall have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise between a member or members and the component society to which said member or members belong. Notice of appeal shall be filed with the Executive Committee of the Council within thirty (30) days of the date of the decision by the component society and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Executive Committee of the Council, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

Section 5. Any member of the Faculty, any committee of the Faculty, or a component society may file charges of unethical conduct in writing against any member of the Faculty. The Executive Committee of the Council may determine, in its discretion whether a hearing is necessary or advisable.

Section 6. A complete copy of the charges specifying the alleged unethical practice shall be promptly sent to the accused. If the Executive Committee of the Council determines that a hearing on said charges should be held, all parties shall be informed of the date, hour and place of the hearing scheduled to consider the charges which date shall not be less than ten days from the date of mailing the charges to the accused.

Section 7. All parties to the hearing may be represented by legal counsel at any hearing held by the Executive Committee of the Council.

Section 8. The Executive Committee of the Council shall adopt rules of procedure governing disciplinary actions as shall meet with the approval of the Council. All interested parties shall be furnished with copies of the rules.

Section 9. The Executive Committee of the Council may impose any of the following penalties: reprimand; suspension of imposition of penalty upon condition that the breach of ethics involved is corrected; suspension from membership generally or for a definite period or until the breach of ethics involved is corrected; and expulsion from membership. Expulsion from membership shall require a two-thirds vote of the Executive Committee of the Council.

Section 10. The accused member shall have the right to appeal the decision of the Executive Committee of the Council to the Judicial Council of the American Medical Association.

Section 11. In all matters of Judicial nature applying to Article XIII, there shall be at least five members of the Executive Committee present.

COMMITTEE DISCHARGED

On motion of Dr. Schaefer, the Professional Fee Fund Committee was finally discharged with the thanks of the House of Delegates.

HOUSE ADJOURNED

Whereupon, by unanimous consent, the House adjourned at 3:40 o'clock.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, Secretary



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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

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ANNUAL MEETING
April 6, 9, 1966

MINUTES

The 253rd meeting, first of the 168th Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was held at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, at 8:05 PM, Tuesday, April 26, 1966, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Doctors: John G. Ball, Montgomery County; Edward M. Barczak, Baltimore City; Richard D. Bauer, Council; E. I. Baumgartner, Council; Harry McB. Beck, Baltimore City; Donald W. Benson, Baltimore City; Horace W. Bernton, Montgomery County; M. McKendree Boyer, Past-president; Wendell J. Burkett, Kent County; Read N. Calvert, Montgomery County; Robert vL. Campbell, President; Douglas G. Carroll, Baltimore City; *Katharine A. Chapman, Montgomery County; Robert G. Chambers, Baltimore City; Henry V. Chase, Council; Archie R. Cohen, Washington County; H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Baltimore City; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore City; John B. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; J. Sheldon Eastland, Past-president; William C. Ebeling, Council; Emanuel S. Ellison, Baltimore City; Robert W. Farr, Council; Whitmer B. Firor, Past-president; Russell S. Fisher, Council; *Charles J. Foley, Jr., Harford County; *Harold H. Gist, Washington County; Seymour Goldgraben, Cecil County; *Paul F. Guerin, Baltimore City; William B. Hagan, Prince George's County; John C. Harvey, Baltimore City; John S. Haught, Prince George's County; William G. Helfrich, Baltimore City; Philip W. Heuman, Harford County; James P. Jarboe, St. Mary's County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Fayne A. Kayser, Council; Lauriston L. Keown, Baltimore City; Robert C. Kimberly, Council; Howard F. Kinnamon, Past-president; *John I. F. Knud-Hansen, Talbot County; C. Rodney Layton, Queen Anne's County; Herbert H. Leighton, Garrett County; F. Ford Loker, Baltimore City; Charles R. MacDonald, Anne Arundel County; William J. McClafferty, Baltimore City; Karl F. Mech, Council; Philip W. Mercer, Carroll County; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald Mintzer, Baltimore City; Andrew C. Mitchell, Wicomico County; Frank K. Morris, Board of Medical Examiners; *Arturo M. Monteiro, Charles County; Howard T. Morse, Montgomery County; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Past-president; William A. Pillsbury, Secretary; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas Reid, Frederick County; Paul F. Richardson, Baltimore City; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Thaddeus C. Siwinski, Baltimore County; R. Kennedy Skipton, Prince George's County; John N. Snyder, Baltimore County; Aaron C. Sollod, Baltimore City; *William G. Speed, III, Baltimore City; Omar D. Sprecher, Jr., Washington County; Harvey B. Stone, Past-president; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; *Ivory U. Sully, Jr., Worcester County; Aaron H. Traum, Montgomery County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson Walden, Baltimore City; Hugh W. Ward, Calvert County; J. Arthur Weinberg, Council; Lawrence R. Wharton, Jr., Baltimore City; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Eldridge H. Wolff, Dorchester County; Donald O. Wood, Baltimore County; *Charles E. Wright, Frederick County; George H. Yeager, Past-president; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

The President made several announcements concerning the transaction of business at the meeting and for informational purposes.

MINUTES

The minutes of the September 10, 1965, session; and the January 29, 1966, special session, having been approved by the Executive Committee and having been distributed to all delegates, were presented to the House for information. The minutes of the January 29 session were amended to show the following additional delegate as being present:

Ferd E. Kadan, M.D., Baltimore City

VISITING MEDICAL SOCIETY PRESIDENT

William B. West, M.D., President of the Pennsylvania Medical Society, was introduced to the House and presented greetings from his organization.

NECROLOGY

After the Secretary read the following names of deceased members, the House of Delegates members rose in observance of a moment's silence in respect for their deceased colleagues:

Allegany County	
Trevaskis, R. W.	September 6, 1965
Anne Arundel County	
Field, Edward G.	October 9, 1965
Martin, James R.	November 14, 1965
Baltimore City	
Bishop, George W.	July 6, 1965
Carey, T. Nelson	March 12, 1966
Davidov, Nathan J.	November 25, 1965
Fox, Leon A.	June 5, 1965
Goldstein, Albert E.	February 22, 1966
Gordy, Lyle L.	March 22, 1965
Hundley, J. Mason, Jr.	December 9, 1965
Kunkowski, Mitchell F.	December 25, 1965
Levin, Milton	November 16, 1965
Levy, Isidore I.	June 27, 1965
Lord, Mason F.	November 16, 1965
Marino, Frank C.	April 17, 1965
Molling, Peter A.	September 7, 1965
Moses, Bessie L.	March 25, 1965
Ridgely, Irwin O.	December 28, 1965
Rowland, William M.	February 28, 1966
Smith, Frank R., Jr.	March 31, 1965

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Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

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Baltimore County

Collins, Jack C.	August 16, 1965

Caroline County

Lennon, W. E.	December 30, 1965
Small, Horace Leon	April 14, 1965

Garrett County

Wenzel, J. W.	October 20, 1965

Montgomery County

Chow, Charles Ching-Te	August 1, 1965
Cross, Merrill M.	November 13, 1965
Cushard, William G.	July 11, 1965
Hare, Robert A.	May 29, 1965
Nelson, Donald	December 14, 1965
Vacca, Aldo	February 12, 1966

Prince George's County

Eisenberg, Herman	November 29, 1965

St. Mary's County

Gill, Joseph E.	July 29, 1965

Talbott County

DeGroot, V. M.	December 30, 1965

Washington County

Shealy, Walter H.	April 15, 1966

Wicomico County

Bishop, James R.	December 16, 1964

Worcester County

Cohen, Paul	November 28, 1965

Affiliate

Langeluttig, H. Vernon	January 31, 1966

TREASURER'S REPORT AND AUDITOR'S REPORT

The Treasurer then presented the 1966 budget for information, it having been adopted by the Council in accordance with the Bylaws. The report of the Treasurer for the year 1965 having been distributed, the auditor's report was adopted.

NOMINEE FORM FOR SECURITIES ADOPTED

The Treasurer then presented a supplemental report and recommended the adoption of Nominee Form for securities of the Faculty. The following resolution was adopted:

Resolved, That the Maryland National Bank as agent for the Medical and Chirurgical Faculty of the State of Maryland, be and is hereby authorized to transfer, or cause to be transferred, all stocks and other registerable securities now held or hereafter to be acquired by the Medical and Chirurgical Faculty of the State of Maryland to the name of the bank's nominee "All & Co."; and

Resolved, That the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland is hereby authorized to execute any and all instruments necessary, proper or desirable for that purpose.

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, the following members who had received the recommendation of the Council, were elected to Emeritus Membership:

Baltimore City	J. Edmund Bradley, M.D.
	Nicholson J. Eastman, M.D.
Baltimore County	Mary McK. Cushing, M.D.
	Robert Hening, M.D.
Dorchester County	Simon Virkutis
Kent County	Manfred J. Gerstley, M.D.
	Eugene Kester, M.D.
Montgomery County	J. Marion Bankhead, M.D.
	Edith H. Weigert, M.D.
	Naomi Lucius, M.D.
Talbot County	H. Dabney Kerr, M.D.

EDUCATIONAL FUND APPROPRIATION

On motion of the Chairman of the Committee on Postgraduate Education, Preventive Medicine and Public Health, the following motion was adopted unanimously:

That the House of Delegates appropriate from the Educational Fund an additional amount up to $10,000 to be used through December 31, 1966, by the Continuing Medical Education Program Subcommittee to continue and expand the MEDIC Network.

NOMINATING COMMITTEE REPORT

The Secretary, on behalf of the Nominating Committee, presented the following slate of officers, the Chairman of the Nominating Committee being deceased:

President-elect
- Richard D. Bauer, Adelphi (President-elect 1966-67; President 1967-68)

First Vice-president
- Houston S. Everett, Baltimore

Second Vice-president
- J. Howard Beard, Annapolis

Third Vice-president
- Francis J. Townsend, Ocean City

Secretary
- William A. Pillsbury, Timonium

Treasurer
- Karl F. Mech, Baltimore

Councilors
- William Carl Ebeling, Baltimore, Central District (1970)
- J. Arthur Weinberg, Baltimore, Central District (1970)
- John F. Schaefer, Baltimore, Central District (1970)
- John Collins Harvey, Baltimore, Central District (1970)
- William G. Speed, III, Baltimore, Central District (1970)
- Eldridge H. Wolff, Cambridge, Eastern District (1970)
- William B. Hagan, Riverdale, South Central District (1969) (to assume office 1966)
- Henry P. Laughlin, Bethesda, South Central District (1970)

Delegate to American Medical Association
- Russell S. Fisher, Baltimore (Jan. 1, 1967-Dec. 31, 1969)

Alternate Delegate to American Medical Association
- M. McKendree Boyer, Damascus (Jan. 1, 1967-Dec. 31, 1969)

Committee on Program and Arrangements
- Arlie R. Mansberger, Jr., Baltimore (1971)

Library and History Committee
- Katharine A. Chapman, Kensington (1972)

Finney Fund Committee
- Richard G. Coblentz, Baltimore (1972)

Board of Medical Examiners
- Elmer G. Linhardt, Eastport (June 1966-June 1970)

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



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Each chewable tablet contains: nicotinic acid (niacin) 75 mg. and aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

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William L. Stewart, Westminster (June 1966-June 1970)

The floor was opened to further nominations for these officers, and there being none, nominations were, by general consent, closed, the election to be held at the second meeting of the session, Friday, April 29, 1966, at the Faculty Building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 11:45 AM, April 28, 1966, at the Alcazar.

FIFTY YEAR PIN PRESENTATION

The President, on behalf of the Faculty, then presented Fifty-Year pins to those members who were able to be present at this session. The following members were so honored at this meeting:

Clarence I. Benson, Port Deposit
Paul W. Clough, Baltimore
G. C. Coulbourne, Marion Station
Frank W. Hachtel, Baltimore
John F. Hogan, Sr., Baltimore
Kenneth B. Jones, Church Creek
John T. King, Baltimore
G. A. Kohler, Smithsburg
Ernest G. Marr, Baltimore
Robert H. Riley, Catonsville
John G. Runkel, Baltimore
G. L. Stickney, Baltimore
Harvey B. Stone, Baltimore

VIET NAM PLAQUES PRESENTATION

The President, on behalf of the American Medical Association, then presented Plaques of Recognition for voluntary service in Viet Nam for 60 days to:

Robert E. Eby, M.D., Olney, Md.
(December, 1965—February, 1966)
Stephen M. Nagy, M.D., Baltimore, Md.
(September, 1965—November, 1965)

A plaque for Richard W. TeLinde, M.D., Baltimore, Md. (March 1963-April, 1963) is to be presented at a later date. Dr. TeLinde was unable to be present.

REPORT OF AMA DELEGATES

The report of the Faculty's Delegates to the American Medical Association was filed, after a request for comments with respect to a proposed $25 increase in the AMA dues received no response.

BYLAWS COMMITTEE REPORT

Dr. O'Donnell, Bylaws Committee chairman, on its behalf, moved the adoption of the following Bylaw amendments which, after debate, were adopted in each case by more than a two-thirds vote:

ARTICLE III, Section 6

To amend Article III, Section 6, by substituting for it the following new Sections 6 and 7 (the remaining sections of the Article automatically being renumbered).

Section 6. The House of Delegates may impose an assessment which shall be paid with, and at the same time as, dues by all active members. The failure of a member to pay an assessment shall be treated as a failure to pay dues as provided in this Article. Notice of a proposal to impose an assessment, and the amount thereof, shall be sent to all delegates at least sixty days before the session at which action is taken, and no amendment shall be in order which would have the effect of increasing the amount of the proposed assessment above that for which notice was given.

Section 7. The Council may, upon the request of a member's component society, remit a member's dues or assessments for reasons of illness, financial hardship or temporary service in the armed forces or the United States Public Health Service.

To amend Article XV by adding: "Provided that any amendment which proposes to increase dues or levy an assessment for any class of membership shall be sent to all delegates at least sixty days before the session at which action is to be taken."

Any amendment to these bylaws submitted by the Bylaws Committee and sent to all delegates with the call to the session may be adopted by the House of Delegates by a two-thirds vote, provided that any amendment which proposes to increase dues or levy an assessment for any class of membership shall be sent to all delegates at least sixty days before the session at which action is to be taken.

To amend the bylaws by inserting after Article IX the following new Article X (succeeding articles to be automatically renumbered):

Section 1. There shall be a Med-Chi Insurance Trust composed of six Trustees, and it shall have the powers and duties as are provided from time to time by the Trust Agreement and any amendments thereto.

Section 2. Two Trustees of the Med-Chi Insurance Trust shall be appointed by the President as soon as practicable after the annual session each year for a term of three years or until their successors are appointed and qualified. The President shall promptly appoint a Trustee to fill the unexpired term in the event of any vacancy among the Trustees caused by resignation, death, or removal.

To amend Article X, Committees, by inserting after Section 7 the following new section 8 (succeeding sections to be automatically renumbered):

Section 8. *A FINANCE COMMITTEE* to advise and counsel the Treasurer regarding the Faculty's financial and investment program shall be composed of the Treasurer and four other members, one of whom shall be appointed by the President each year for a four-year term. The President shall annually designate the chairman of the committee.

INFORMATION COMMITTEE REPORTS

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions:

Secretary—William A. Pillsbury, M.D.
Board of Medical Examiners—Frank K. Morris, M.D., Secretary
Executive Secretary—Mr. John Sargeant
Library and History Committee and Finney Fund Committee—Louis Krause, M.D., and George G. Finney, Sr., M.D.
Curator—Edwin David Weinberg, M.D.
Committee on Program and Arrangements—John C. Harvey, M.D.
American Medical Association Education and Research Foundation Committee—William S. Stone, M.D.
Economics Committee—Paul F. Guerin, M.D.
Editorial Board, Maryland State Medical Journal—George H. Yeager, M.D.
Committee on Emotional Health—Augusto J. Esquibel, M.D.
Fee Schedule Committee—William G. Speed, III, M.D.
Ad Hoc Finance Committee—Karl F. Mech, M.D.
Legislative Committee—B. Martin Middleton, M.D.
Liaison Committee—John F. Schaefer, M.D.
Faculty Representatives on the Maryland Joint Council to Improve the Health Care of the Aged—Albert E. Goldstein, M.D. (Deceased)
Mediation Committee—Wolcott L. Etienne, M.D.

In fact, there's as much iron...250 mg. ...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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Medicolegal Committee—Howard F. Kinnamon, M.D.
Membership Committee—Nathan E. Needle, M.D.
Occupational Health Committee—John R. Davis, M.D.
Public Relations Committee—Manning W. Alden, M.D.
(a) Regular Report
(b) Supplemental Report
Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program

SUPPLEMENTAL FEE SCHEDULE COMMITTEE REPORT

Dr. Speed, on behalf of the Fee Schedule Committee, presented the following resolutions for consideration of the House of Delegates. On more than a two-thirds vote, it was agreed to consider them and, after debate and amendment, they were adopted as follows:

Resolved, That this House of Delegates reaffirm the Principle of Resolution 1 S/65, as adopted September 10, 1965, "that usual and customary fees be paid to private practicing physicians rendering care to . . . medical care program patients"; and

Resolved, That the President be required to appoint a Subcommittee of the Fee Schedule Committee to deal with (a) all problems relating to PL 89-97 (Medicare) as it pertains to physicians' services; and (b) to deal with the fiscal intermediary for physicians' fees as they pertain to Title XVIII or XIX of this law, such Subcommittee to be composed of at least four members, not excluding Faculty members who are not members of the Fee Schedule Committee.

Thereupon, the House adjourned at 10:00 PM.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, Secretary

ELECTION OF THE BOARD OF MEDICAL EXAMINERS OF MARYLAND

A general meeting of the Medical and Chirurgical Faculty of the State of Maryland was held on Thursday, April 28, 1966 at 11:45 a.m., at the Alcazar, Cathedral and Madison Streets, Baltimore, Maryland, for the purpose of electing two members of the Board of Medical Examiners of Maryland.

The President, Robert vL. Campbell, M.D., presided and called the meeting to order.

The names of the two nominees were presented to the General Meeting, as follows:

Elmer G. Linhardt, M. D. (June 1966-June 1970)
William L. Stewart, M. D. (June 1966-June 1970)

Nominations from the floor were requested. There being none, the Chairman declared nominations closed.

Election took place by acclamation, and the Secretary, William A. Pillsbury, M. D., was instructed to cast one ballot for those nominated.

There being no further business, the meeting adjourned at 11:55 AM.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, Secretary

MINUTES

The 254th meeting, second of the 168th annual session of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, was held at the Faculty Building, 1211 Cathedral Street, Baltimore, Maryland, at 9:00 AM, Friday, April 29, 1966, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors: John G. Ball, Montgomery County; Richard D. Bauer, Council; *Philip J. Bean, St. Mary's County; Harry McB. Beck, Baltimore City; Horace W. Bernton, Montgomery County; Wendell J. Burkett, Kent County; Read N. Calvert, Montgomery County; Robert vL. Campbell, President; Douglas G. Carroll, Baltimore City; *Katharine A. Chapman, Montgomery County; Robert G. Chambers, Baltimore City; Henry V. Chase, Council; Archie R. Cohen, Washington County; H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Baltimore City; Worth B. Daniels, Jr., Baltimore City; John B. De Hoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; J. Sheldon Eastland, Past-president; William C. Ebeling, Council; Emanuel S. Ellison, Baltimore City; Robert W. Farr, Council; James McC. Finney, Harford County; Whitmer B. Firor, Past-president; Russell S. Fisher, Council; *Harold H. Gist, Washington County; William B. Hagan, Prince George's County; John C. Harvey, Baltimore City; John S. Haught, Prince George's County; Lauriston L. Keown, Baltimore City; Norman Levin, Baltimore City; F. Ford Loker, Baltimore City; Charles R. MacDonald, Anne Arundel County; William J. McClafferty, Baltimore City; Karl F. Mech, Treasurer; Philip W. Mercer, Carroll County; John E. Miller, Baltimore City; *Robert Miller, Allegany County; Donald Mintzer, Baltimore City; Andrew C. Mitchell, Wicomico County; Frank K. Morris, Board of Medical Examiners; Howard T. Morse, Montgomery County; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Past-president; William A. Pillsbury, Secretary; *Carolyn S. Pincock, Montgomery County; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas Reid, Frederick County; Paul F. Richardson, Baltimore City; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Salvador Rossello, Baltimore City; Edwin Ruzicka, Talbot County; John F. Schaefer, Council; Emmanuel Schimunek, Baltimore City; Thaddeus C. Siwinski, Baltimore County; R. Kennedy Skipton, Prince George's County; John N. Snyder, Baltimore County; Aaron C. Sollod, Baltimore City; Omar D. Sprecher, Jr., Washington County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson Walden, Baltimore City; Hugh W. Ward, Calvert County; William H. F. Warthen, Past-president; J. Arthur Weinberg, Council; *William C. Weintraub, Prince George's County; Daniel Wilfson, Jr., Baltimore City; Charles H. Williams, Baltimore County; Donald O. Wood, Baltimore County; *Charles E. Wright, Frederick County; John D. Young, Jr., Baltimore City; Raymond M. Yow, Council.

Present also for the meeting were staff personnel.

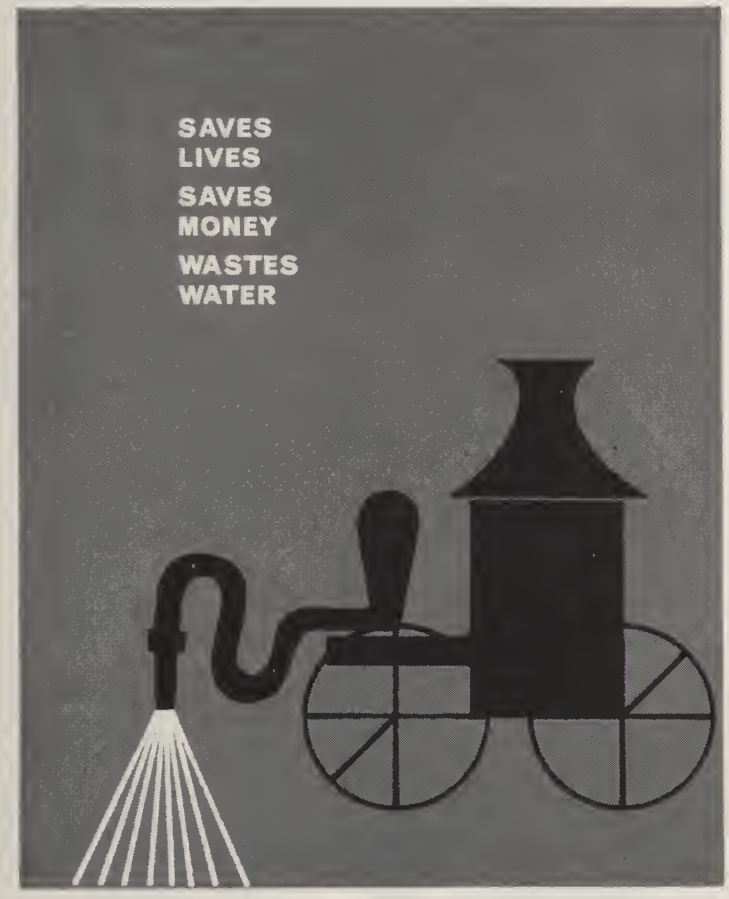
The President made several announcements regarding the transaction of business at the meeting and for informational purposes.

BOARD OF MEDICAL EXAMINERS ELECTIONS

The President advised the House of Delegates of the election of the members of the Board of Medical Examiners at the General Meeting held on April 28, 1966:

Elmer G. Linhardt, M.D., Eastport (June, 1966-June, 1969)

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*



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Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

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William L. Stewart, M.D., Westminster (June, 1966-June, 1969)

ELECTION OF OFFICERS

There being no further nominations from the floor and there being only one candidate for each of the positions, by unanimous consent the ballot was dispensed with. The following were then elected by voice vote:

President-elect
Richard D. Bauer, Adelphi (President-elect 1966-67; President 1967-68)
First Vice-president
Houston S. Everett, Baltimore
Second Vice-president
J. Howard Beard, Annapolis
Third Vice-president
Francis J. Townsend, Ocean City
Secretary
William A. Pillsbury, Timonium
Treasurer
Karl F. Mech, Baltimore
Councilors
William Carl Ebeling, Baltimore, Central District (1970)
J. Arthur Weinberg, Baltimore Central District (1970)
John F. Schaefer, Baltimore, Central District (1970)
John Collins Harvey, Baltimore, Central District (1970)
William G. Speed, III, Baltimore, Central District (1970)
Eldridge H. Wolff, Cambridge, Eastern District (1970)
William B. Hagan, Riverdale, South Central District (1969)
(to assume office 1966)
Henry P. Laughlin, Bethesda, South Central District (1970)
Delegate to American Medical Association
Russell S. Fisher, Baltimore (Jan. 1, 1967-Dec. 31, 1969)
Alternate Delegate to American Medical Association
M. McKendree Boyer, Damascus (Jan. 1, 1967-Dec. 31, 1969)
Committee on Program and Arrangements
Arlie R. Mansberger, Jr., Baltimore (1971)
Library and History Committee
Katharine A. Chapman, Kensington (1972)
Finney Fund Committee
Richard G. Coblentz, Baltimore (1972)

REFERENCE COMMITTEE REPORT RESOLUTION 1 A/66 ADOPTED

Dr. Hagan, on behalf of the Reference Committee, reported to the House with respect to Resolution 1 A/66, and recommended that it be adopted. The House adopted Resolution 1 A/66, which read as follows:

Whereas, It is now the declared policy of the American College of Radiology that members of the College shall separate their professional fees from hospital charges and present their own bills to all patients expected to pay for services; and

Whereas, The House of Delegates of the American Medical Association on October 3, 1965, stated, "Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians."; and

Whereas, Congress established under the Medicare Law, PL 89-97, provisions covering Radiology solely as a medical service, and radiologists are obligated to obey these legislative provisions, and

Whereas, The identification of radiology as a hospital service has led physicians away from training in the specialty or radiology, and has jeopardized the future of radiological practice and thus of all medical care due to professional personnel shortages; and

Whereas, Separate billing for professional services is feasible and desirable for *all* patients served by radiologists in hospital departments, just as it is for surgeons, obstetricians, internists, anesthesiologists, and other practitioners of medicine; now, therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland supports the policy of the American College of Radiology, the American Medical Association, and of Medicare law PL 89-97, of separating professional fees from hospital charges; and

Resolved, That copies of this resolution be sent to the American College of Radiology, the Hospital Council of Maryland, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

RESOLUTION 2 A/66 ADOPTED

Dr. Hagan, on behalf of the Reference Committee, recommended that Resolution 2 A/66 be adopted. The House adopted Resolution 2 A/66, which read as follows:

Whereas, The shortage of properly qualified medical technologists remains acute, appears to be worsening and will become more and more acute in response to the increasing demands of coming years, and in view of the fact that there is a profession in which the work involved is becoming increasingly complex and important to patient care so that it is felt action must be taken at once to relieve the situation; therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland requests that the Maryland General Assembly appropriate the initial sum of at least fifty thousand dollars for the establishment of a formal School of Medical Technology at the University of Maryland and that sufficient appropriations be made annually thereafter for maintenance of same; and

Resolved, That the University of Maryland be commissioned and designated to establish and operate this school on a scale specifically designed to benefit equitably all geographic areas in the State of Maryland and expressly with the purpose of relieving present and future shortages in medical technologists in all areas of the State of Maryland; and

Resolved, That this School of Medical Technology be established within the University of Maryland in an organizational manner analogous to that of the Schools of Medicine, Dentistry and Pharmacy; that the standards maintained in this school be satisfactory to the American Medical Association, the American Society of Clinical Pathologists, and the American Society of Medical Technologists, and to their respective Maryland component societies, and that the graduates be awarded the B.S. degree and be eligible by examination for certification and the professional designation M.T. (ASCP).

ADDITIONAL RECOMMENDATION

Dr. Hagan, on behalf of the Reference Committee, recommended adoption of the following two recommendations, with regard to the implementation of Resolution 2 A/66, which the House adopted:

(1) That all appropriate universities and colleges in Maryland be requested to give this possibility some study and be advised that the counsel and advice of the Faculty and its members are available in this area.

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Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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(2) That the Faculty's Legislative Committee and approved Legislative Representative at the General Assembly sessions be instructed to work closely with the University of Maryland in insuring that funds for development of this course of training are retained in the University of Maryland budget.

RESOLUTION ADOPTED

Dr. Ball, on behalf of the Montgomery County Medical Society, moved adoption of a resolution. The House, after approving its consideration by more than a two-thirds vote, took a five minute recess at 9:40 am.

The House reconvened at 9:45 am, and after debate and amendment adopted the resolution as follows:

Whereas, The enactment of Public Law 89-97 (Medicare) will create many problems and, while this resolution does not imply endorsement of such legislation, we are of the opinion that the medical profession throughout the nation has a responsibility to the public in assisting in resolving any problems relating to care being provided under PL 89-97, such as Physicians' Care, Home Care, Extended Care Facilities and Hospital Care; therefore be it

Resolved, That the Faculty's Delegates to the American Medical Association be instructed to introduce a resolution into the AMA House of Delegates at the 1966 annual session in Chicago, substantially as follows:

"*Resolved,* That all constituent associations of the American Medical Association be urged to establish Medicare Coordinating Committees in communities throughout the areas they serve, such Committees to provide local medical leadership within the proper scope of the Physician/Patient Relationship in (a) developing policies and standards to meet problems arising under PL 89-97 (Medicare); (b) provide a forum for the exchange of facts and ideas affecting Community Agencies."

SUBJECTS RULED OUT OF ORDER

Dr. M. B. Levin, being granted the privilege of addressing the House of Delegates, raised three points of order.

Accordingly, the Chair ruled that all the points of order were not well taken.

(1) The Baltimore City Medical Society has selected the allotted number of delegates and alternates to the House of Delegates of the Medical and Chirurgical Faculty of Maryland.

(2) The decision of the Courts in the case of *Levin vs Medical and Chirurgical Faculty, et al,* finally determined that the Faculty need not provide for proxy or mail voting and the issue is closed.

(3) It was proper for the Special Session of the House at which the $50 assessment was imposed to amend the assessment resolution; such amendment did not exceed the scope of the notice of the meeting, and the present point of order was not timely made.

There being no further business, the President made several announcements, following which he introduced to the House of Delegates the new President, J. Morris Reese, M.D., who assumed the Chair and, following brief acceptance remarks, and by unanimous consent, declared the House adjourned *sine die,* at 10:10 AM.

Respectfully submitted,
WILLIAM A. PILLSBURY, M.D., Secretary

When depressed patients say:



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"I'm tired all day long"

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Norpramin (desipramine hydrochloride) reverses the signs and symptoms of depression including sleep disturbances, feeling of sadness, guilt, worthlessness, anxiety and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, more active and less weighed down by their problems.

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Policy & Planning Committee
Medical Annals

TREASURER

Mr. President and Members of the House of Delegates:

The auditor's statement for 1965 together with our budget for 1966 have already been distributed to you. We are in fine shape financially. I am sure you all have had a chance to look over these statements, and I shall be glad to answer any questions you might have. Your particular attention is invited to the restricted fund statement contained in the auditor's report. This indicates current accumulated income from these sources as well as the purposes for which such money may be spent.

At the present time, I have one additional recommendation to make. Over the years we have been somewhat hampered by the fact that some companies will not accept anything but a formal resolution by this House as authority for sale of stock. As you know, we have investment counsel in T. Rowe Price and Company, who advise us on our portfolio of investments.

We have discussed this entire matter at some length in the Ad Hoc Finance Committee and have consulted with our legal counsel, investment counsel, and Maryland National Bank, the custodian of our investment portfolio. All agree that our investments should be registered in the nominee form of registration. This is common practice with organizations, and we have the following resolution to present with the recommendation that it be adopted:

RESOLVED: That the Maryland National Bank as agent for the Medical and Chirurgical Faculty of the State of Maryland, be and is hereby authorized to transfer, or cause to be transferred, all stocks and other registerable securities now held or hereafter to be acquired by the Medical and Chirurgical Faculty of the State of Maryland to the name of the bank's nominee "All & Co."

And that the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland is hereby authorized to execute any and all instruments necessary, proper or desirable for that purpose.

I want to express sincere thanks to the staff for their great help, and especially to Mr. Sargeant and to Mr. Harrison, our accountant-office manager, to whom we are indebted for the expert keeping of our accounts.

Respectfully submitted,
KARL F. MECH, MD, Treasurer

EXPLANATORY NOTES ON 1966 PROPOSED BUDGET

Budgetary items for 1966 are predicated on actual cost for 1965. Only items where there is a substantial change will have explanatory notes.

A. Contributions

Student AMA	$250.00
National Society for Medical Research	50.00
Miscellaneous (Maryland League for Nursing)	300.00
TOTAL	$600.00

B. Salaries

Reflected in this figure are anticipated salary increments during 1966, plus offsetting amounts shown under receipts from Faculty's Insurance Trust and the Baltimore City Medical Society for services of its employees on Faculty payroll.

In addition, all employees salaried and hourly rated are included in this figure, decreasing similar amounts under library and household and janitorial services items.

C. Travel

The following items are budgeted for travel during 1966:

Professional Convention Management Association and Medical Exhibitors Association, Las Vegas, Nevada,
January 3-6 — One Staff Member

National Conference on Federal Medical Assistance Programs, Chicago, Illinois,
January 20-21 — One Staff Member

Annual Medicolegal Conference, Chicago, Illinois,
April 15-16 — One Staff Member

Medical Society Executives Assn. (1 Day) and AMA Annual Meeting (5 Days), Chicago, Illinois,
June, 1966 — One Staff Member, Three Delegates, Senior Alternate Delegate

Medical Society Executives Assn. (1 Day) and AMA Annual Institute (2 Days), Chicago, Illinois,
August, 1966 — Two Staff Members

American Medical Association House of Delegates (4 Days), Las Vegas, Nevada,
December, 1966 — One Staff Member, Three Delegates, Senior Alternate Delegate

Journal

State Medical Journal Advertising Bureau Meeting, Chicago, Illinois,
October, 1966 — One Staff Member

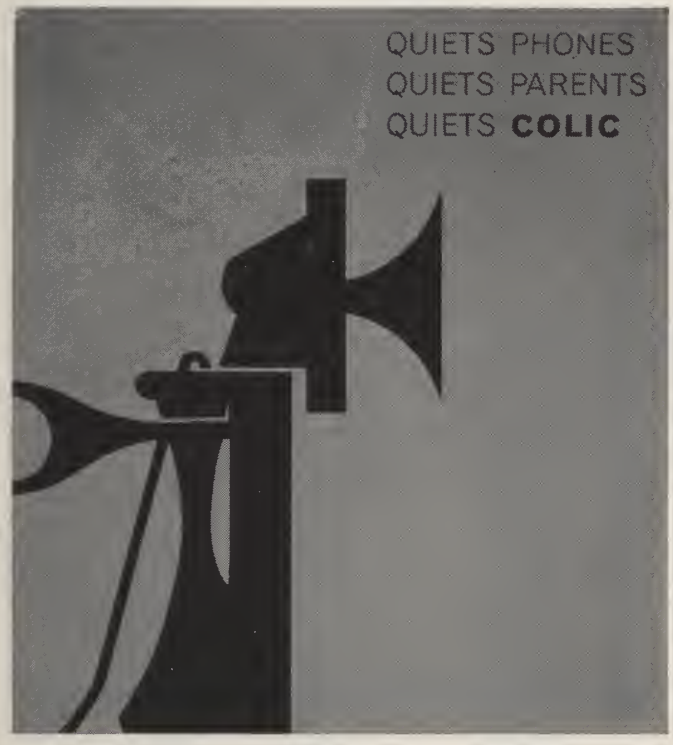
American Medical Writers' Assn. Meeting, New York City,
October, 1966 — One Staff Member

Library

Advisory Board, Special Libraries Assn., Albuquerque, New Mexico,
January 20-22 — One Staff Member

Special Libraries Assn. Annual Meeting, Minneapolis, Minnesota,
May 29-June 3 — One Staff Member

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



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ESTIMATED INCOME
1966

	1965 Thru November		1966 Budget
Dues			
B. C. M. S.	$104,654.00	$106,000.00	
Counties	101,906.00	101,900.00	
B. C. D. S.	2,190.00	2,190.00	
		$208,750.00	$210,090.00
Rents & Services			
B. C. M. S.	$ 23,957.00	$ 24,548.00	
Board of Medical Examiners	5,000.00	5,760.00	
Maryland League for Nursing	385.00	420.00	
Med-Chi Insurance Trust	—0—	10,023.00	
		$ 29,342.00	$ 40,751.00
Investments			
General Purpose		$ 3,781.15	$ 3,700.00
Medical Journal		$ 60,878.78	$ 65,000.00
Annual Meeting		$ 17,791.34	$ 16,000.00
Other		$ 7,808.48	$ 7,000.00
Total		$328,351.75	$342,541.00

ESTIMATED EXPENDITURES
1966

	Budget 1965	Actual through November 1965	Budget 1966	
Auditing	$ 2,000.00	$ 1,064.25	$ 1,500.00	
Legal	4,000.00	2,925.00	4,000.00	
Contributions	600.00	600.00	600.00	A
Fuel	2,000.00	1,330.50	2,000.00	
Gas, Electricity, Water	4,500.00	4,458.67	5,000.00	
Telephone & Telegraph	4,800.00	4,422.52	4,800.00	
Postage	3,700.00	5,020.64	5,000.00	
Household & Janitorial	1,500.00	2,201.06	1,500.00	
Property Maintenance	2,500.00	1,802.70	2,500.00	
Insurance	2,000.00	2,002.50	2,000.00	
Equipment Rental	3,000.00	2,123.32	3,000.00	
New Equipment	1,000.00	163.61	2,000.00	
Equipment Maintenance	1,500.00	1,555.93	500.00	
Stationery & Supplies	3,000.00	3,976.51	4,000.00	B
Salaries	132,702.00	113,616.72	145,255.00	
Social Security	3,700.00	3,121.54	5,065.00	
Unemployment Compensation	2,500.00	1,347.77	2,600.00	
Employee's Insurance Program	3,400.00	2,888.36	3,400.00	
Employee's Pension Program	10,000.00	7,740.22	7,000.00	
Supplementary Hours	2,000.00	1,449.06	2,000.00	
Travel	5,000.00	4,852.94	6,000.00	C
Printing—Committees	2,500.00	1,433.91	2,000.00	
Printing—Gov'n bodies	1,500.00	2,145.77	2,000.00	
Legislation	5,000.00	3,077.16	5,000.00	D
Library	19,050.00	13,985.56	4,310.00	E
Journal Expense	60,000.00	62,208.91	70,000.00	
Annual & S. A. Meetings	21,000.00	20,137.70	21,000.00	
Miscellaneous Expenses	6,500.00	5,777.73	4,000.00	
Interest to Coggins Fund	5,500.00	5,500.00	5,500.00	
Presidential Fund	—0—	—0—	1,000.00	
Total	$316,452.00	$282,930.56	$324,530.00	

Medical Library Association Meeting, Boston, Massachusetts, June 5-9	Two Staff Members
Regional Medical Library Assn., Baltimore, Maryland, Fall	Two Staff Members

Increase in mileage allowance to 12¢ per mile.
Any travel for which the Faculty is reimbursed by the AMA or other affiliated, allied or associated groups is approved without reference to the Executive Committee. The increase in total dollars for 1966 on travel is occasioned by the distance of the Clinical session of the American Medical Association scheduled for Las Vegas.

D. Legislative

Operation of Legislative First Aid Room	$1,200.00
Distribution of Legislative Newsletter (5 issues)	2,000.00
Copies of legislation	200.00
Legislative Representatives expenses (Travel, meals, telephone, etc.)	500.00
Expenditures for federal legislation	1,100.00
TOTAL	$5,000.00

E. Library Expenses

Total per Library Budget	$24,670.00
Less: Amount included in Salaries Account	20,360.00
Library Expense of General Fund	$4,310.00

Journal Subscriptions, books and binding are not included in above, but are purchased out of income from specific funds for Library purposes.

Light, Heat, Telephone, Payroll Taxes, etc., are also excluded.

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

BALTIMORE, MARYLAND

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For the Year Ended December 31st, 1965

GENERAL FUND

EXHIBIT B

Income

Dues—Baltimore City Dental Society	$2,190.00	
—Baltimore City Medical Society	104,629.00	
—County Medical Society	101,906.00	$208,725.00
Rents and Services		
Baltimore City Medical Society	23,957.00	
Others	6,300.00	30,257.00
Meetings—Annual and Semi-Annual Exhibits		17,791.34
Journal—Advertising	69,279.63	
—Subscriptions	862.42	70,142.05
Maryland Hospital Service Fees		1,036.09
Addressograph Service		800.42
Interest on Savings Accounts		5,638.43
Miscellaneous		1,416.55
		335,806.88
Transfer from Consolidated Fund—Income for General Purposes—Exhibit F		4,156.72
Total Income		$339,963.60

Expenses

Accounting Fees	1,064.25	
Communications Expense—Postage, Telephone and Telegraph	9,461.58	
Contributions	600.00	
Equipment Rental	2,681.29	
Fuel	1,775.70	
Gas, Electricity and Water	4,794.88	
Household and Janitorial Services	2,423.05	
Insurance—General	2,045.15	
—Hospitalization	2,795.86	
Journal Expense—Printing and Commissions	76,572.29	
Legal Fees	3,175.00	
Legislation	3,077.16	
Printing Committees	1,570.41	
Printing—Governing Bodies	2,180.02	
Property Maintenance	2,030.56	
Meetings—Annual and Semi-Annual	20,467.55	
Office Supplies	3,737.13	
Purchases of Equipment	2,140.94	
Pension and Major Medical Contribution	8,080.22	
Salaries	124,063.12	
Social Security Tax—Employer's Portion	3,485.14	
Unemployment Insurance—United States	292.34	
—State of Maryland	1,444.16	
Travel	6,437.28	

Expenses—Continued

Supplementary Hours Expense	1,585.98	
Library	5,646.26	
Interest—Coggins Fund	5,500.00	
Fees—Implementation of Faculty Insurance Program	3,249.76	
Master Seal Plaques	1,218.25	
Miscellaneous	1,959.10	
Total Expenses		305,554.43
Excess of Income Over Expenses—To Exhibit C		34,409.17

STATEMENT OF SURPLUS

For Year Ended December 31st, 1965

GENERAL FUND

	Exhibit C
January 1st, 1965—Balance to Credit of Account	$58,410.72
Addition	
Excess of Income Over Expenses—For Year Ended December 31st, 1965—Exhibit B	34,409.17
December 31st, 1965—Balance to Credit of Account—To Exhibit A	92,819.89

STATEMENT OF INCOME, EXPENSES AND APPROPRIATION

For Year Ended December 31st, 1965

CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT D

Income			
Investments—General			
Bonds			
United States Government and Municipals	$970.00		
Public Utilities, Railroads, etc.	2,359.39	$3,329.39	
Stocks			
Preferred	376.26		
Common	13,001.05	13,377.31	
Interest on Special Savings Account—The Savings Bank of Baltimore		285.75	
		16,992.45	
Less—Agency Fees	827.96		
—Broker's Fees	1,040.13	1,868.09	
Net Income—Exhibit F		15,124.36	
Investments—Eugene F. Cordell Fund—Exhibit F			
Stocks			
Common	386.00		
Less—Agency Fee	23.16	362.84	$15,487.20
Interest on Savings Accounts—The Savings Bank of Baltimore—Exhibit F			971.65
			16,458.85
Expenses and Appropriation—Exhibit F			
Library Purposes—General		7,690.17	
Library Payroll, Maintenance, etc.—General Fund		4,156.72	
Lectureship		598.84	
Cordell Fund	600.00		
Appropriation for Amount due from Ruhrah Fund to General Fund	6,625.08	7,225.08	19,670.81
Excess of Expenses and Transfers Over Income—To Exhibit E			3,211.96

STATEMENT OF CAPITAL

For Year Ended December 31st, 1965

CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT E

January 1st, 1965—Balance to Credit of Account—Exhibit F	$34,626.80
Deduction	
Excess of Expenses Over Income for Year Ended December 31st, 1965—Exhibit D	3,211.96
December 31st, 1965—Balance to Credit of Account—To Exhibits A-1 and F	31,414.84

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES

For Year Ended December 31st, 1965

CONSOLIDATED FUND—INCOME ACCOUNT

Exhibit F

FUND	Distributive Share Per Cent	Balance January 1st, 1965	INCOME RECEIVED DURING YEAR			Balance January 1st, 1965 Plus Receipts	EXPENSES				BALANCE DECEMBER 31ST, 1965	
			Savings Account Interest	INVESTMENT INCOME (Distributive Share)	INVESTMENT INCOME (Direct)		Library	Transferred to General Fund (Exhibit B)	Lectureship	Other	Cash, Investments and Dividends Receivable	Cash on Deposit
Baker	.65	11.82	.52	85.67		98.01	84.65				13.36	12.34
Barker, Lewellys F.	.39	7.45	.01	51.41		58.87	50.45				8.42	7.46
Bowen, Josiah S.	9.17	154.18	....	1,208.64		1,362.82		1,187.46			175.36	154.18
Bressler, Frank C.	1.80	31.01	....	237.25		268.26		234.03			34.23	31.01
Cordell, Eugene Fauntleroy	3.64	17,888.00	360.70	479.76	362.84	19,091.30				600.00	18,491.30	9,113.91
Cowles, Nellie N.	.75	821.18	31.88	98.85		951.91	9.00				942.91	853.06
Ellis, Charles M.	....	75.20	....	1,944.00		2,019.20		2,019.20			....	....
Finney, John M. T.	8.40	5,264.69	205.13	1,107.15		6,576.97	638.55		196.44		5,741.98	5,469.82
Frick, William F.	15.02	251.71	6.50	1,979.69		2,237.90	1,951.30				286.60	258.21
Friedenwald, Julius F.	.75	324.94	11.81	98.85		435.60		420.34			15.26	336.75
Harlan, Herbert	.76	220.49	9.27	100.17		329.93	26.60				303.33	229.76
McCleary, Standish	.75	223.85	8.05	98.85		330.75	66.60		155.00		109.15	231.90
Osler Endowment	1.40	605.53	22.14	184.52		812.19	784.57				27.62	627.67
Osler Testimonial	7.75	4,645.53	180.34	1,021.48		5,847.35	2,313.65				3,533.70	4,825.87
Ruhrah, John	40.79	681.95	....	5,376.27		6,058.22	1,764.80			6,625.08	−2,331.66	681.95
Stokes, William Royal	3.09	242.78	7.26	407.28		657.32			100.00		557.32	250.04
Trimble, Isaac Ridgeway	2.64	3,137.81	123.81	347.96		3,609.58			147.40		3,462.18	3,261.62
Woods, Hiram	2.25	38.68	4.23	296.56		339.47		295.69			43.78	42.91
	100.00	34,626.80	971.65	15,124.36	362.84	51,085.65	7,690.17	4,156.72	598.84	7,225.08	31,414.84	26,388.46
			Exhibit E	Exhibit D			Exhibit D				Exhibit E	To Summary

Summary—To Exhibit A-1

Cash

Individual Accounts—above	$26,388.46	
Special Account	13,222.90	
	$39,611.36	
Dividends Receivable	1,901.46	$41,512.82

Cordell Fund

Cash	299.09	
Investments	8,598.54	8,897.63
		$50,410.45
Less—Accounts Payable to General Fund		18,995.61
		$31,414.84

STATEMENT OF CAPITAL

December 31st, 1965

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

EXHIBIT G

FUND	PURPOSE	BALANCE JANUARY 1ST, 1965	NET PROFIT ON SECURITY SALES	BALANCE DECEMBER 31ST, 1965
Baker	Book of Materia Medica	$1,194.88	$4.91	$1,199.79
Barker, Lewellyn F.	Library	716.94	2.95	719.89
Bowen, Josiah S.	General	16,815.41	69.29	16,884.70
Bressler, Frank C.	General	3,299.95	13.60	3,313.55
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	6,675.49	27.50	6,702.99
Cowles, Nellie N.	Books on Neurology	1,376.72	5.67	1,382.39
Ellis, Charles M.	General	8,258.46	....	8,258.46
Finney, John M. T.	Books, Journals and Lectureships on Surgery	15,392.89	63.47	15,456.36
Frick, William F.	Maintenance — Frick Library, Purchase Books and Journals	27,532.20	113.49	27,645.69
Friedenwald, D. Julius	Maintenance of Friedenwald Room	1,376.73	5.67	1,382.40
Harlan, Herbert	Books on Ophthalmology	1,396.97	5.74	1,402.71
McCleary, Standish	Lectureship and Books on Pathology	1,376.73	5.67	1,382.40
Osler—Endowment	Permanent Endowment for Library by Bequest of Dr. Osler	2,562.08	10.58	2,572.66
Osler—Testimonial	Medical Books and Maintenance of Osler Hall	14,204.14	58.56	14,262.70
Ruhrah, John	Library Books, Journals, etc.	74,778.44	308.18	75,086.62
Stokes, William Royal	Lectureships and Books on Bacteriology or Pathology	5,671.70	23.35	5,695.05
Trimble, Isaac Ridgeway	Lectureship Only	4,843.01	19.95	4,862.96
Woods, Hiram	General	4,133.52	17.00	4,150.52
		191,606.26	755.58	192,361.84
			Schedule G-1	To Exhibit A-1

STATEMENT OF SECURITIES SOLD AND EXCHANGED

For Year Ended December 31st, 1965

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

SCHEDULE G-1

PAR VALUE OR SHARES	DESCRIPTION	AMOUNT RECEIVED	COST	GAIN OR (—LOSS)
	PUBLIC UTILITIES AND RAILROADS, ETC.—BONDS			
2,000.00	Pennsylvania Railroad—General Mortgage, Gold Bond, Serial A—4½%—Due June 1st, 1965	$2,000.00	$2,081.68	—$81.68
2,000.00	Pennsylvania Railroad—General Mortgage, Gold Bond, Serial A—4¼%—Due April 1st, 1981	1,821.58	2,082.50	—260.92
	COMMON STOCKS			
100	Magnavox Company	4,651.52	3,988.75	662.77
	STOCK RIGHTS			
262	Pacific Telephone and Telegraph Company	182.79	....	182.79
	FRACTIONAL SHARES			
4/100	Shulton, Inc.—Class A Common	1.37	....	1.37
	EXCHANGE OF			
10	Bethlehem Steel Corporation—7% Cumulative Preferred	....	1,498.75	—1,498.75
	FOR			
1,000.00	Bethlehem Steel Corporation—Sub—Debenture—4½%—Due January 1st, 1990 (Received $750.00 in Cash Together with $1,000.00 Par Value Bond)	1,750.00	....	1,750.00
		10,407.26	9,651.68	755.58
				To Exhibit G

STATEMENT OF CAPITAL

For Year Ended December 31st, 1965

FUNDED RESERVE

INCOME ACCOUNT

		Exhibit H
January 1st, 1965—Balance to Credit of Account		$481.34
Additions		
Dividends	655.70	
Interest—United States Government Bonds	62.50	
—Savings Account	124.05	842.25
		1,323.59
Deduction		
Agency Fee		43.10
December 31st, 1965—Balance to Credit of Account—To Exhibit A-2		1,280.49

PRINCIPAL ACCOUNT

January 1st, 1965—Balance to Credit of Account	12,930.68
No changes During the Year Ended December 31st, 1965	....
December 31st, 1965—Balance to Credit of Account—To Exhibit A-2	12,930.68

STATEMENT OF CAPITAL

For Year Ended December 31st, 1965

MEDICAL ANNALS FUND

	Exhibit I
January 1st, 1965—Balance to Credit of Account	$1,145.59
Addition	
Interest on Savings Account	40.20
December 31st, 1965—Balance to Credit of Account	1,185.79

STATEMENT OF CAPITAL

For the Year Ended December 31st, 1965

HARVEY G. BECK LECTURESHIP FUND

EXHIBIT J

INCOME ACCOUNT

January 1st, 1965—Balance to Credit of Account		$778.02
Additions		
Dividends	$164.00	
Interest—Savings Account	35.74	199.74
		977.76
Deductions		
Agency Fees	9.84	
Reimbursement to General Fund for Expenditures	100.00	109.84
December 31st, 1965—Balance to Credit of Account—To Exhibit A-3		867.92

PRINCIPAL ACCOUNT

January 1st, 1965—Balance to Credit of Account	2,079.10
No Changes During Year Ended December 31st, 1965	....
December 31st, 1965—Balance to Credit of Account—To Exhibit A-3	2,079.10

STATEMENT OF CAPITAL

For the Year Ended December 31st, 1965

JESSE C. COGGINS—LECTURESHIP FUND

EXHIBIT K

January 1st, 1965—Balance to Credit of Account	$5,123.63
Addition	
Interest—Savings Account	180.78
	5,304.41
Deduction	
Reimbursement to General Fund for Expenditures	100.00
December 31st, 1965—Balance to Credit of Account—To Exhibit A	5,204.41

STATEMENT OF CAPITAL

For the Year Ended December 31st, 1965

AMOS KOONTZ MEMORIAL FUND

EXHIBIT L

PRINCIPAL ACCOUNT

January 1st, 1965—Balance to Credit of Account	....
Additions	
Contributions Received During Year	$2,439.00
Interest on Savings Account	10.58
	2,449.58
Deduction	
Lectureship Expense	31.75
December 31st, 1965—Balance to Credit of Account—To Exhibit A-5	2,417.83

STATEMENT OF CAPITAL

For Year Ended December 31st, 1965

EDUCATIONAL FUND

EXHIBIT M

PRINCIPAL ACCOUNT

January 1st, 1965—Balance to Credit of Account	....
Addition	
Contributions and Assessments received during year	95,629.67
	$95,629.67
Deduction	
Legislative and Educational Expenses	24,685.15
December 31st, 1965—Balance to Credit to Account—To Exhibit A	70,944.52

STATEMENT OF CAPITAL

For Year Ended December 31st, 1965

PLANT FUND

EXHIBIT N

January 1st, 1965—Balance to Credit of Account	$701,451.64
Addition	
Assessments	16,595.00
	718,046.64
Deduction	
Building—Painting and Repairs	1,568.81
December 31st, 1965—Balance to Credit of Account—To Exhibit A	716,477.83

BALANCE SHEET—DECEMBER 31st, 1965

EXHIBIT A

*The appraised value of portraits as of December 31st, 1963 was $65,000,000—an increase of $51,000,000 over prior years. All other Personal Property appraised as of December 31st, 1949, with subsequent additions at cost.

ASSETS

General Fund

Cash

Maryland National Bank—Savings Account	$91,774.75		
Petty Cash Funds	150.02	$91,924.77	
Loyola Federal Savings and Loan Association—Hundley Fund—See Designated—Contra		3,126.81	
Baltimore Federal Savings and Loan Association—Pension Fund—See Designated—Contra		1,834.44	$96,886.02

Accounts Receivable

Dues, Journals, Subscriptions, etc.	16,796.73	
Faculty Insurance Program—Fees and Related Expenses	7,224.24	
	24,020.97	

Due from Other Funds

Consolidated Fund—Income Account	18,996.61	
Educational Fund	2,240.48	
Harvey G. Beck—Lectureship Fund	100.00	
George M. Boyer—Lectureship Fund	159.82	
Jesse C. Coggins—Lectureship Fund	100.00	
J. Mason Hundley—Lectureship Fund	100.00	
	21,696.91	
Employees	75.00	45,792.88
Loan Receivable—Plant Fund—Contra		30,000.00

Deferred Charges

Air Travel	425.00	
Annual Meeting	400.00	
Journal Postage	200.00	
Insurance Premiums	1,355.48	2,380.48
Total General Fund Assets		175,059.38

Endowment and Other Special Funds

Consolidated Fund—Exhibit A-1

Income Account	50,411.45	
Principal Account	192,361.84	242,773.29

LIABILITIES AND CAPITAL

General Fund

Liabilities

Maryland National Bank—Overdraft		18,065.89
Accounts Payable—Trade	9,046.33	
—American Medical Association—Dues Collected	9,575.00	
—Plant Fund—Contra	1,780.00	
—County Medical Association	6,025.00	
—Amos Koontz Memorial Fund	253.25	26,679.58

Payroll Taxes

Withholding

United States—December, 1965	1,366.54	
State of Maryland—4th Quarter, 1965	764.34	
Old Age Benefit Tax—December, 1965	359.32	

Unemployment Insurance

United States—1965	292.34	
State of Maryland—4th Quarter, 1965	96.39	2,878.93

Designated Funds

For—Library Account—Books and Journals	1,016.71	
—Dental Books	27.13	
—The J. Mason Hundley Memorial Fund—Due General Fund	100.00	
Capital	3,026.81	
		4,170.65
Contra	3,126.81	51,795.05
Reserve for Pension Fund—On Deposit—Contra		1,834.44
Deferred Income—1966 Dues		28,610.00
Surplus—Exhibit C		92,819.89
Total General Fund—Liabilities, Reserves and Capital		175,059.38

Endowment and Other Special Funds

Consolidated Fund—Exhibit A-1

Income Account

Due General Fund	$18,996.61	
Capital	31,414.84	50,411.45

Funded Reserve—Exhibit A-2			
Income Account		1,280.49	
Principal Account		13,411.02	14,691.51
Harvey G. Beck—Lectureship Fund—Exhibit A-3			
Income Account		967.92	
Principal Account		2,079.10	3,047.02
Jesse C. Coggins—Lectureship Fund			
Cash—Maryland National Bank			5,304.41
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account		26,151.96	
Principal Account		102,000.00	128,151.96
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			2,691.93
Amos Koontz Memorial Fund—Exhibit A-5			
Principal Account			2,417.83
Educational Fund			
Cash—Maryland National Bank			73,185.00
Medical Annals Fund			
Cash—Union Trust Company of Maryland			1,185.79
Total Endowment and Other Special Funds			473,448.74
Plant Fund			
Cash—Maryland National Bank			100.00
Accounts Receivable—General Fund—Contra			1,780.00
Fixed Assets (No Depreciation Provided)			
1215-1217 Cathedral Street—Land—Cost		19,118.95	
1209-1213 Cathedral Street			
Land and Building—Cost	110,635.76		
Improvements—Cost	331,525.47	442,161.23	
*Personal Property			
Library Books and Journals	231,370.00		
Office, Library, Fixtures, Antiques and Museum Pieces	77,349.48		
Portraits	65,000.00	373,719.48	834,999.66
			836,879.66
Grand Total—All Funds			1,485,387.78

Principal Account			
Capital		192,361.84	242,773.29
Funded Reserve—Exhibit A-2			
Income Account			
Capital		1,280.49	
Principal Account			
Due Income Account	480.34		
Capital	12,930.68	13,411.02	14,691.51
Harvey G. Beck—Lectureship Fund—Exhibit A-3			
Income Account			
Due General Fund	100.00		
Capital	867.92	967.92	
Principal Account			
Capital		2,079.10	3,047.02
Jesse C. Coggins—Lectureship Fund			
Due General Fund		100.00	
Capital—Exhibit K		5,204.41	5,304.41
Jesse C. Coggins—New Building Fund—Exhibit A-4			
Income Account			
Liabilities			
Due Principal Account	13,916.98		
Capital	12,234.98	26,151.96	
Principal Account			
Capital		102,000.00	128,151.96
George M. Boyer—Lectureship Fund			
Liabilities			
Due General Fund		159.82	
Capital		2,532.11	2,691.93
Amos Koontz Memorial Fund—Exhibit A-5			
Capital			2,417.83

Educational Fund		
Liabilities		
Due General Fund	2,240.48	
Capital—Exhibit M	70,944.52	73,185.00
Medical Annals Fund		
Capital		1,185.79
Total Endowment and Other Special Funds		473,448.74
Plant Fund		
Liabilities		
Jesse C. Coggins—New Building Fund	88,833.02	
General Fund—Contra	30,000.00	
Accrued Expense—Painting and Repairs	1,568.81	120,401.83
Capital—Exhibit N		716.477.83
Total Plant Fund Liabilities and Capital		836,879.66
Grand Total—All Funds		1,485,387.78

BALANCE SHEET—DECEMBER 31st, 1965
CONSOLIDATED FUND

EXHIBIT A-1

ASSETS

Income Account				
Cash—*The Savings Bank of Baltimore*—Exhibit F				
Individual Accounts		$26,388.46		
Special Account	$13,222.90			
Special Account—Contra	1.00	13,223.90	$39,612.36	
Dividends Receivable—Held by Maryland National Bank—Exhibit F.			1,901.46	
Investments				
Eugene Cordell Fund—Held by				
Maryland National Bank—Agent—Exhibit F				
Cash		299.09		
Common Stock		8,598.54	8,897.63	
Total Income Account Assets—To Exhibit A				$50,411.45
Principal Account				
Held by Maryland National Bank—Agent				
Cash			41.10	
Investments—At Cost				
United States Government and Municipal Bonds		28,830.00		
Public Utilities and Railroads, etc.—Bonds		66,830.69		
Stocks—Preferred		7,679.17		
—Common		88,980.88	192,320.74	
Total Principal Account Assets—To Exhibit A				192,361.84
Grand Total—Income and Principal Account Assets—To Exhibit A				242,773.29

LIABILITIES AND CAPITAL

Income Account—To Exhibit A			
Liabilities			
Due General Fund			
For Expenditures for Year Ended December 31st, 1965—Exhibits A and F		18,995.61	
From Special Savings Account—Contra		1.00	18,996.61
Capital—Exhibit E			31,414.84
Total Income Account Liabilities and Capital			50,411.45
Principal Account—To Exhibit A			
Capital—Exhibit G			192,361.84
Grand Total—Income and Principal Account—Liabilities and Capital—To Exhibit A			242,773.29

BALANCE SHEET—DECEMBER 31st, 1965
FUNDED RESERVE

EXHIBIT A-2

ASSETS

Income Account			
Cash—Savings Bank of Baltimore		$800.15	
Due from Principal Account—Contra		480.34	
Total Income Account Assets—To Exhibit A			$1,280.49
Principal Account			
Investments—Funded Reserve—Held by—*Maryland National Bank—Agent*			
Cash		178.71	
United States Government Bonds	$2,284.38		
Common Stocks	10,947.93	13,232.31	
Total Principal Account Assets—To Exhibit A			13,411.02
Grand Total—Income and Principal Account Assets—To Exhibit A			14,691.51

LIABILITIES AND CAPITAL

Income Account—To Exhibit A			
Capital—Exhibit H			1,280.49
Principal Account—To Exhibit A			
Liabilities			
Due Income Account—Contra		480.34	
Capital—Exhibit H		12,930.68	
Total Principal Account—Liabilities and Capital—To Exhibit A			13,411.02
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A			14,691.51

BALANCE SHEET—DECEMBER 31st, 1965
HARVEY G. BECK LECTURESHIP FUND

EXHIBIT A-3

ASSETS

Income Account			
Cash—Savings Bank of Baltimore—To Exhibit A			967.92
Principal Account			
Investments Held by Maryland National Bank—Agent			
Cash		109.36	
Common Stock		1,969.74	
Total Principal Account Assets—To Exhibit A			2,079.10
Grand Total—Income and Principal Account Assets—To Exhibit A			3,047.02

in diarrhea

LOMOTIL® Tablets / Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



is a corker

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

LIABILITIES AND CAPITAL

Income Account

Liabilities—To Exhibit A

Due General Found	100.00
Capital—Exhibit J	867.92
Total Income Account Liabilities and Capital—To Exhibit A	967.92
Principal Account—To Exhibit A	
Capital—Exhibit J	2,079.10
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A	3,047.02

BALANCE SHEET—DECEMBER 31st, 1965
JESSE C. COGGINS—NEW BUILDING FUND

EXHIBIT A-4

ASSETS

Income Account

Cash—Loyola Federal Savings and Loan Association	$25,401.96	
Accrued Interest on Principal Account Investments	750.00	
Total Income Account Assets—To Exhibit A		$26,151.96
Principal Account		
Accounts Receivable		
Due from Plant Fund	88,083.02	
Due from Income Account—Contra	13,916.98	
Total Principal Account Assets—To Exhibit A		102,000.00
Grand Total—Income and Principal Account Assets—To Exhibit A		128,151.96

LIABILITIES AND CAPITAL

Income Account—To Exhibit A

Liabilities

Due to Principal—Contra	13,916.98	
Capital (Includes $5,984.98 of Interest Earned During Year)	12,234.98	
Total Income Account Liabilities and Capital—To Exhibit A		26,151.96
Principal Account—To Exhibit A		
Capital		102,000.00
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A		128,151.96

BALANCE SHEET—DECEMBER 31st, 1965
AMOS KOONTZ—MEMORIAL FUND

EXHIBIT A-5

ASSETS

Principal Account

Cash—Loyola Federal Savings and Loan Association	$2,155.01	
Accounts Receivable—Due from General Fund	253.25	
Interest Receivable—Savings Account	9.57	
Total Principal Account Assets—To Exhibit A		2,417.83

LIABILITIES AND CAPITAL

Principal Account

Liabilities	None
Capital—Exhibit L	2,417.83
Total Principal Account Liabilities and Capital—To Exhibit A	2,417.83

March 16th, 1966

CERTIFICATE

The Medical and Chirurgical Faculty
of the State of Maryland,
1211 Cathedral Street,
Baltimore, Maryland 21201

Gentlemen:

We have made an audit of the records in the office of the Treasurer of the Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31st, 1965. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31st, 1965 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Respectfully submitted,
Wooden, Benson & Walton
Members of American Institute of Certified Public Accountants

SECRETARY

Mr. President and Members of the House of Delegates:

The following component societies have 100% paid-up membership by January 31, 1965: Charles, Howard, Queen Anne's, Somerset, Talbot, and Worcester Counties.

At the request of the component societies, the Faculty handled the dues-billing for the following: Allegany, Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Dorchester, Frederick, Garrett, Harford, Kent, Queen Anne's, Washington, Wicomico, and Worcester Counties.

Membership in the American Medical Association as of December 31, 1965, totaled 2,825.

Blue Cross and Blue Shield enrollment through the Faculty group plan increased from 1,298 in 1964 to 1,376 in 1965.

During the calendar year 1965, 403 meetings were held in the Faculty building by medically oriented groups.

Complete records of all Faculty committees and subcommittees are kept in the Faculty office. These are available for the perusal of Faculty members or chairmen so they may be aware of previous actions in these areas.

Respectfully submitted,
William A. Pillsbury, MD, secretary

COUNCIL

Mr. President and Members of the House of Delegates:

Both the Council and the Executive Committee met at regular intervals during the past year. Business transacted at these meetings has been summarized in the *Maryland State Medical Journal* so that all members are aware of the range of activities in which the Society is engaged.

The Executive Committee held several meetings with its counterpart of the Hospital Council. Discussion was primarily limited to a completion of the various Gruehn Committee report's recommendations and to various facets of the Medicare legislation (PL 89-97).

Physicians defense was ratified for 29 members requesting this privilege. We again emphasize the necessity for members to remain in good standing in order to retain their rights to this benefit. Individually, physicians cannot afford to be without this added protection against suit, and is provided only through Faculty membership.

A complete record of all activity, in detail, is maintained in the Faculty office and is available to those authorized to examine these minutes. Data on any activity, individually, may be obtained on request by any member who has a legitimate need for it.

Business routinely transacted includes the making and

approving of various official appointments, acting on recommendations from Faculty committees, approving special expenditures of funds, and acting on various staff matters.

The Council recommends emeritus membership for the following:
J. Edmund Bradley, M.D., Baltimore City
Nicholson J. Eastman, M.D., Baltimore City
Mary McK. Cushing, M.D., Baltimore County
Manfred J. Gerstley, M.D., Kent County
Eugene Kester, M.D., Kent County
J. Marion Bankhead, M.D., Montgomery County
Edith H. Weighert, M.D., Montgomery County
H. Dabney Kerr, M.D., Talbot County

Respectfully submitted,
Russell S. Fisher, MD, chairman

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

This year concludes eight years of service with the Medical and Chirurgical Faculty as its executive secretary. During the past year much reorganization and reassignment of duties have taken place, making for a more efficient working force and better utilization of staff time.

The results of staff activity are apparent in the various committee, subcommittee, and board reports made elsewhere. Nearly all such groups were staffed with office personnel, resulting in timely implementation of recommendations and prompt completion of minutes, correspondence, and reports.

A record number of inquiries was handled from the public, from the members, and from associated organizations. Liaison with allied professional groups continues at a high level. All of this work has been done without increasing the number of personnel on the Faculty payroll. At times, however, it has been necessary to "job-lot" work out for completion in order to meet necessary deadlines.

The Faculty has an efficient, functioning operation that is the envy of many other professional groups in the community. While many of our own members may not praise our efforts, members of other groups consider the Faculty a well-organized and effective force in the state.

Respectfully submitted,
John Sargeant

AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION COMMITTEE

Mr. President and Members of the House of Delegates:

In 1965, Maryland physicians gave $9,605 to medical education through the AMA-ERF. The check was formally presented at the AMA clinical meeting in Philadelphia by Robert vL. Campbell, MD, Maryland delegate to the AMA and president of the Medical and Chirurgical Faculty.

From the national total collected in 1965, the University of Maryland School of Medicine receives $15,738.43 and the Johns Hopkins University School of Medicine receives $10,282.99. As has been the custom, the checks will be presented to the deans of the respective medical schools at the Presidential Dinner.

Respectfully submitted,
William S. Stone, MD, chairman
Albert L. Anderson, MD
Richard D. Bauer, MD
Newland E. Day, MD
Abraham Genecin, MD
William B. Gunther, MD
Bender B. Kneisley, MD
J. Douglass Shepperd, MD
Vernon M. Smith, MD
Thomas B. Turner, MD

BOARD OF MEDICAL EXAMINERS

Mr. President and Members of the House of Delegates:

Examinations given during the year show the following results:

Applications received for examination			583
Second year students examined and re-examined	119		
Postponed, withdrawn, or did not appear	75		
Failed to complete	2		
Re-examined after license to meet requirements of other State Boards	1		
Not eligible for license			197
Examined in second part of examination	125		
Complete examination given	179		
Re-examined	82		
Eligible for license			386
Passed—American Graduates	168		
Passed—Foreign Graduates	116	284	
Failed—American Graduates	14		
Failed—Foreign Graduates	88	102	386

The American schools which had failures are as follows:

Hahnemann	1
Howard	5
Jefferson	1
Johns Hopkins	2
Meharry	2
University of Maryland	1
University of Miami	2

Licenses issued after written examination	284
Licenses issued after special examination	2
Licenses issued by endorsement of other states' licenses	148
Licenses issued by endorsement of National Board Certificates	188
Total licenses issued	622
Licenses revoked	1
Licentiates certified to other states	278
Copies of licenses issued	9
American graduates examined and re-examined	182
Foreign graduates examined and re-examined	204
Foreign graduates approved for examination	141
Written inquiries from foreign graduates (approximately)	422
Office interviews with foreign graduates (approximately)	250

Telephone inquiries from foreign graduates (approximately)	1,500
Telephone inquiries concerning registration of physicians	500
Registration certificates issued from 1/1/65 to 12/31/65	1,186
Total registration of physicians possessing Maryland licenses to 12/31/65	10,537

Revocation of medical license

The medical license of Bennett A. Robin, MD, was revoked on February 4, 1965, for having made a false statement in violation of 18 U.S.C. 1001. The case has been appealed.

Hearing

Yuen K. Yuan, MD, was charged with having bribed a public official in violation of 18 U.S.C. The Board's decision is not to be finalized until the expiration of Dr. Yuen K. Yuan's probation. In the interim, Dr. Yuan will report quarterly to the Executive Committee to give an account of his activities.

Reprimanded

Joseph Blum, MD, for having accepted a fee on a contingency basis.

Gunther D. Hirsch, MD, for advertising in violation of the Medical Practice Act.

Edward M. Rehak, MD, and Theodore Carski, MD, of the Maryland Diagnostic Laboratory, for issuing an unethical publication in violation of the Medical Practice Act.

Christopher Mendelis, MD, for prescribing drugs indiscriminately.

Appearing before Executive Committee Periodically to give a report on rehabilitation and professional activities, respectively: John R. Smith, Jr., MD, and Ralph F. Young MD.

Training in an approved Maryland Hospital

The Executive Committee encountered difficulty regarding the requirement of foreign graduates spending one year in approved Maryland hospital. The Board, therefore, has deleted the word "approved" in reference to a Maryland hospital.

Special Examination (oral)

After finding the following physicians eminently qualified for licensure in the State of Maryland, a medical license was issued to Leon A. Akopiantz, MD, and Ralph D. Dwork, MD

Sixty-First Annual Congress of Medical Education and Licensure

Dr. Walter C. Merkel, Dr. Vernon H. Norwood, Dr. Frank K. Morris, and Dr. Joseph D. B. King attended the Congress in Chicago on February 6-9, 1965.

Mexican and Canadian physicians practicing in Maryland without a license in time of disaster

This Board is in agreement with the Faculty statement on Item 313 in Civil Defense Medical Services to the Budget and Finance Committee Legislative Council, dated October 12, 1964, but the word "license" should be eliminated in permitting Mexican and Canadian physicians to practice medicine in the State of Maryland in time of disaster.

BRIEF SUMMARY OF ACTIVITIES FROM
January 1, 1966, to March 15, 1966

Hearings

A hearing was held on revocation of the medical license of Ulysses G. Bourne, MD, for violation of the federal law in reference to selling pep pills. The Board unanimously decided to take no further action.

An agreement has been reached in the case of Bennett A. Robin, MD. In lieu of his withdrawing his appeal, the Board will delay revoking his license for a period of three months beginning May 1, 1966, and ending August 1, 1966.

The Board notified Ralph F. Young, MD, that he has been relieved of further responsibility to the Board of Medical Examiners of Maryland in connection with the hearing on revocation and that the case is now closed.

Rent

The Board was notified by the Medical and Chirurgical Faculty that the rent for Osler Hall would be increased from $80 to $125 per day beginning January 1, 1967.

Sixty-second Annual Congress of Medical Education and Licensure

Drs. Walter C. Merkel, Vernon H. Norwood, and Frank K. Morris attended the Congress in Chicago on February 5-8, 1966.

Respectfully submitted,
FRANK K. MORRIS, MD, secretary
WYLIE M. FAW, MD
JOSEPH D. B. KING, MD
JOHN H. HORNBAKER, MD
KARL F. MECH, MD
WALTER C. MERKEL, MD
WILBER R. ELLIS, JR., MD
VERNON H. NORWOOD, MD

BYLAWS COMMITTEE

Mr. President and Members of the House of Delegates:

The Bylaws Committee has had one meeting to consider various bylaw changes. These are presented herewith for action by the House of Delegates:

ARTICLE III, Section 6

To amend Article III, Section 6, by substituting for it the following new Sections 6 and 7 (the remaining sections of the Article automatically being renumbered).

OLD

(*Italicized* portion to be deleted)

Section 6. The House of Delegates may impose an assessment in addition to dues to be paid with, and in the same manner as dues by all Active members. The Council may, upon the request of a member's component society, remit a member's dues and/or assessment for reasons of illness, financial hardship or temporary service in the Armed Forces or United States Public Health Service.

NEW

(CAPS portion to be added)

SECTION 6. THE HOUSE OF DELEGATES MAY IMPOSE AN ASSESSMENT WHICH SHALL BE PAID WITH, AND AT THE SAME TIME AS, DUES BY ALL ACTIVE MEMBERS. THE FAILURE OF A MEMBER TO PAY AN ASSESSMENT SHALL BE TREATED AS A FAILURE TO PAY DUES AS PROVIDED IN THIS ARTICLE. NOTICE OF A PROPOSAL TO IMPOSE AN ASSESSMENT, AND THE AMOUNT THEREOF, SHALL BE SENT TO ALL DELEGATES AT LEAST SIXTY DAYS BEFORE THE SESSION AT WHICH ACTION IS TAKEN, AND NO AMENDMENT SHALL BE IN ORDER WHICH WOULD HAVE THE EFFECT OF INCREASING THE AMOUNT OF THE PROPOSED ASSESSMENT ABOVE THAT FOR WHICH NOTICE WAS GIVEN.

SECTION 7. THE COUNCIL MAY, UPON THE REQUEST OF A MEMBER'S COMPONENT SOCIETY, REMIT A MEMBER'S DUES OR ASSESSMENTS FOR REASONS OF ILLNESS, FINANCIAL HARDSHIP OR TEMPORARY SERVICE IN THE ARMED FORCES OR THE UNITED STATES PUBLIC HEALTH SERVICE.

To amend Article XV by adding: "Provided that any amendment which proposes to increase dues or levy an assessment for any class of membership shall be sent to all delegates at least sixty days before the session at which action is to be taken."

OLD

Any amendment to these bylaws submitted by the Bylaws Committee and sent to all delegates with the call to the session may be adopted by the House of Delegates by a two-thirds vote.

NEW

(CAPS portion to be added)

Any amendment to these bylaws submitted by the Bylaws Committee and sent to all delegates with the call to the session may be adopted by the House of Delegates by a two-thirds vote, PROVIDED THAT ANY AMENDMENT WHICH PROPOSES TO INCREASE DUES OR LEVY AN ASSESSMENT FOR ANY CLASS OF MEMBERSHIP SHALL BE SENT TO ALL DELEGATES AT LEAST SIXTY DAYS BEFORE THE SESSION AT WHICH ACTION IS TO BE TAKEN.

Explanation: The Montgomery County Medical Society has suggested that appropriate changes in the Faculty bylaws be made so as to ensure adequate notice of any increase in dues or levying of assessments. The proposed amendments would provide for a 60-day advance notice of any such changes, thus enabling component societies to meet and duly consider such changes before the set meeting date.

This in no way prohibits the House of Delegates from having special meetings on ten days notice to consider important matters other than described above, as presently provided in the bylaws.

To amend the bylaws by inserting after Article IX the following new Article X (succeeding articles to be automatically renumbered):

OLD

(No bylaw in existence)

NEW

Article X

(CAPS portion to be added)

SECTION 1. THERE SHALL BE A MED-CHI INSURANCE TRUST COMPOSED OF SIX TRUSTEES, AND IT SHALL HAVE THE POWERS AND DUTIES AS ARE PROVIDED FROM TIME TO TIME BY THE TRUST AGREEMENT AND ANY AMENDMENTS THERETO.

SECTION 2. TWO TRUSTEES OF THE MED-CHI INSURANCE TRUST SHALL BE APPOINTED BY THE PRESIDENT AS SOON AS PRACTICABLE AFTER THE ANNUAL SESSION EACH YEAR FOR A TERM OF THREE YEARS OR UNTIL THEIR SUCCESSORS ARE APPOINTED AND QUALIFIED. THE PRESIDENT SHALL PROMPTLY APPOINT A TRUSTEE TO FILL THE UNEXPIRED TERM IN THE EVENT OF ANY VACANCY AMONG THE TRUSTEES CAUSED BY RESIGNATION, DEATH, OR REMOVAL.

Explanation:The above bylaw changes regularize the action of the Council taken on September 9, 1965, in connection with the control of the "Med-Chi Insurance Trust," through appropriate procedures already established in precedent.



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nidar®

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

nidar®

Sleep comes easy...lingers...departs naturally

Gentle doses of 4 barbiturates assure uninterrupted sleep

2 barbiturates act fast...in 20 to 30 minutes

2 long-range barbiturates come into play to sustain sleep for up to 8 hours

Tiny amounts of individual barbiturates means Nidar is well tolerated

Patients enjoy a refreshing, clear-headed wake-up

makes sleep irresistible



IN BRIEF:

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

To amend Article X, *Committees*, by inserting after Section 7 the following new Section 8 (succeeding sections to be automatically renumbered):

OLD

(No bylaw in existence)

NEW

(CAPS portion to be added)

SECTION 8. A FINANCE COMMITTEE TO ADVISE AND COUNSEL THE TREASURER REGARDING THE FACULTY'S FINANCIAL AND INVESTMENT PROGRAM SHALL BE COMPOSED OF THE TREASURER AND FOUR OTHER MEMBERS, ONE OF WHOM SHALL BE APPOINTED BY THE PRESIDENT EACH YEAR FOR A FOUR-YEAR TERM. THE PRESIDENT SHALL ANNUALLY DESIGNATE THE CHAIRMAN OF THE COMMITTEE.

Explanation: The above change reflects the instructions of the Council at its November 18, 1965, meeting and the request of the Treasurer and the Ad Hoc Finance Committee. This places into the Bylaws and the Faculty's organizational structure, the Finance Committee which is now functioning.

In addition to the above amendments, the Bylaws Committee considered the suggestion of the Frederick County Medical Society that the Bylaws provide for a referendum if requested by a petition signed by 10% of the active members being carried out by a mailed secret ballot. The bylaws currently provide for a referendum in Article VI, Section 1(c), and it was the opinion of the Bylaws Committee that no further provision is required.

Respectfully submitted,
CHARLES F. O'DONNELL, M.D., chairman
EDMOND J. MCDONNELL, M.D.
M. MCKENDREE BOYER, M.D.
ALBERT E. GOLDSTEIN, M.D.*

*Deceased

CURATOR

Mr. President and Members of the House of Delegates:

The undersigned assumed this post in January, upon the death of Mason F. Lord, MD. I look forward to performing interesting and satisfying work on behalf of the Faculty.

The Council and Treasurer were able to double the usual sum for portrait restoration and appropriate $1,000 this year. This enabled us to restore some of our portraits which might have suffered irreparable damage if the work had been delayed.

During the past year we have added the following items to the Faculty's historical collection:

Medical instruments belonging to Dr. James B. Joyce, given by his daughter, Mrs. Frederick Weiss.

Two electrocautery machines, given by Mrs. C. Ruth Jones.

Portrait of Tristram Thomas, MD, given by University of Maryland Medical School through Dean William S. Stone.

Collection instruments belonging to Lewis H. Gundry, MD, given by his son, Lewis P. Gundry, MD.

Instruments and diploma of Samuel J. Fort, MD, given by his son, Wetherbee Fort, MD

Old diplomas and pictures belonging to James Clagett Robertson, MD, given by his son, Lt. James Robertson.

Photographs of Drs. Koontz, Cullen, etc., and books for library, given by Harvey B. Stone, MD.

On June 17, 1966, Council acknowledged appreciation for bound volume of his collected papers given to library.

We thank these members and non-members who have assisted us in making the Faculty a repository of valuable historical material pertaining to medicine.

During the past year we loaned the Archer Diploma, the first medical school diploma ever issued in the United States, to the University of Pennsylvania on the occasion of its bicentennial celebration. We also loaned several items of historical interest to the Sinai Hospital for its anniversary celebration and other material to the American Association of Abdominal Surgeons.

Respectfully submitted,
E. DAVID WEINBERG, MD, curator

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

SPECIAL CONVENTION, OCT 3, 1965

Legislation and Public Relations

In a special session, convened in Chicago on October 3, the report of the Reference Committee on Legislation and Public Relations was amended and adopted as follows:

Mr. Speaker and Members of the House of Delegates:

Your Reference Committee recognizes the serious nature of the problems before this body and the decisions that must be made on this day—decisions which will affect the future of the practice of medicine for generations to come.

Your Committee heard 125 witnesses speak to twenty separate subjects during seven and one-half hours of testimony. Each witness spoke earnestly, forcefully, temperately, and with personal concern for the welfare of the patient in these United States.

Because of the special nature of the subjects presented to this Special Convention and the interrelationship of the resolutions considered, your Reference Committee, in lieu of dealing with each resolution separately, has considered the intent and the language of all the resolutions. We believe it would be more expedient and practical to present for adoption by this House of Delegates a series of numbered comments, principles and policies which express the position of the American Medical Association on the issues under consideration.

Mr. Speaker, we have endeavored to evaluate, carefully and objectively, the matters before your Committee, and offer the following recommendations:

I. Physician-Patient Relationship

Public Law 89-97 affects the legal, traditional, and ethical concepts of the physician-patient relationship.

Legal counsel for the American Medical Association has stated that an individual physician acting independently and not in concert with others can lawfully refuse to accept any person as a patient who is a beneficiary under the program, or he may elect to treat such persons.

Accepted for information

In response to a request for an opinion by the Speaker, the Judicial Council, on October 1, 1965, rendered the following opinion:

The *Principles of Medical Ethics* are applicable to physicians when they engage in group action as well as when they act individually. Section 4 calls upon physicians to observe all laws. Accordingly, medical organizations must be mindful of the possible consequences of the actions they propose, engage in or encourage.

Under ordinary circumstances, the individual physician acting independently, is ethically free to select his patients. (See Section 5 of the Principles.) (a) He may decline to render medical services to persons covered by the "Health Insurance for the Aged Act." (b) He may choose to treat such persons without charge. (c) He may treat patients with the advance understanding that he will look to them exclusively for payment and that he will or will not in any way help them in obtaining reimbursement for the cost of his services or the cost of associated services.

However, under some circumstances, the physician's freedom to select his patients may be circumscribed by overriding ethical considerations. For example:

1. A physician should respond to any request for his assistance in an emergency.
2. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice sufficient to allow the patient to obtain another physician.
3. If a physician decides not to participate in the Medicare program or decides to limit his participation, he should so advise the patient in advance of treatment. This applies to services rendered by the physician as well as hospital services and other benefits provided under the program.
4. As provided in Section 1 of the *Principles of Medical Ethics,* a physician should not refuse to render medical services to any person if as a result such person will be unable to get necessary medical care.

It should be noted also that Section 6 of the Principles provides that "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause the deterioration of the quality of medical care." If after regulations are promulgated and the Medicare law becomes effective, the individual physician acting independently and not in concert with others, finds it does tend to impair the free and complete exercise of his medical judgment and skill or to cause a deterioration of the quality of medical care, the individual physician would be justified under this Principle in not participating under the law. The physician is ordinarily free to select his patients, subject to such ethical limitations as previously stated in Section 6 of the *Principles of Medical Ethics,* the Bauer Amendment, and in keeping with the nine principles for standards of health care programs adopted at the annual meeting 1965.

Accepted for information

In accepting the Judicial Council's opinion, as reported by the Reference Committee, the House called attention to the fact that this opinion should be read together with the Bauer Amendment (A-1961) and the nine principles for standards of health care programs adopted A-1965; and that these two items be distributed with the Judicial Council's opinion on the ethics involved in physician participation or nonparticipation in the Health Insurance for the Aged Act.

Mr. Speaker, your Reference Committee believes that it is desirable for this House to adopt a statement of policy regarding the traditional physician-patient relationship as it relates to Public Law 89-97. Mr. Speaker, we recommend that the following statement be adopted:

The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

Adopted as Amended

II. Regulations Under Public Law 89-97

It was clear from the testimony received by your Reference Committee that the medical profession has a vital interest in the regulations which are to be promulgated under Public Law 89-97. Hastily drawn, unrealistic regulations could aggravate even further the undesirable effects of this law. Mr. Speaker, we recommend the adoption of the following statement as the present position and policy of the American Medical Association:

(a) The American Medical Association shall continue to meet with representatives of agencies and departments of the Federal Government, to participate in such advisory committees which are created, and to contribute whatever advice and suggestions are deemed advisable and necessary in the formulation and revision of regulations which will help it achieve Medicine's objectives on behalf of the public and the profession.

(b) The American Medical Association urges every physician, regardless of the extent of his involvement, to render whatever advice and assistance he can so that regulatory changes and/or legislative modifications may be suggested or sponsored by the American Medical Association in order that the best interests of the public and the profession may be protected in the provision of medical care.

(c) This House of Delegates expresses confidence in the Board of Trustees of the American Medical Association, its Advisory Committee, and the three-man Consultant Committee on Public Law 89-97 for their continuing efforts to secure regulations which are in the best interests of good patient care.

Adopted as Amended

* * * * * * *

Mr. Speaker, your Reference Committee next considered a number of items related to the primary subjects under consideration:

III. Certification by Physicians

Your Reference Committee recommends the adoption of the following statement of policy:

Current practices and customary procedures with respect to certification for hospital admission and care shall be continued under Public Law 89-97. The AMA Advisory Committee and the Association representatives to the technical advisory committees are advised to seek to accomplish this objective.

Adopted

IV. Blue Shield as Intermediary

Regulations yet to be promulgated will identify the nature of intermediaries under Public Law 89-97. Your Committee offers the following statement:

Blue Shield has, in many areas, demonstrated its ability to provide a competent insurance program. However, the AMA should leave to the state or appropriate local medical society, as the case may be, the expression of any preference for selection of a carrier.

Adopted

V. Reasonable Fees

Concern was expressed with respect to possible disputes between physicians and carriers relative to reasonable fees under the provisions of Public Law 89-97. We recommend the following statement of policy:

In the event of a dispute between physicians and carriers with respect to reasonable, customary, or usual fees, such disputes shall be resolved with the participation of the appropriate local medical society.

Adopted

VI. Utilization Review

Differences of opinion as to the purpose of utilization review committees were expressed. However, there was general agreement that with respect to the composition of such committees, the limitation of membership to include only physicians is preferred.

Accordingly, we recommend the following statement to the House:

Hospital utilization review committees shall be composed of practicing physicians.

Adopted as Amended

Your Reference Committee understands that the Council on Medical Service will conduct a conference on the subject of utilization review committees on November 27 in Philadelphia. Recognizing the importance of this subject matter, your Reference Committee recommends that Resolutions No. 8, 18, and 35 be referred to the Council on Medical Service with instructions that the Association's Advisory Committee as well as the Board of Trustees and the House of Delegates be kept informed of developments in this area.

Adopted

VII. Compensation for Medical Services

Your Reference Committee believes that the physician should be informed fully as to the merits and limitations of billing patients directly for services, or accepting an assignment to enable payment by a federally designated fiscal intermediary, so that the physician can decide for himself in each instance the method of compensation which he prefers. We recommend that the Association take appropriate action to inform physicians regarding the options of payment for services available to them under the law and its regulations.

Adopted as Amended

VIII. Shortage of Hospital Beds

The Oregon Delegation requested a survey of the probable shortage of hospital and related facility accommodations which may occur as a result of the implementation of Public Law 89-97 It also called for the development of a mechanism under which sufficient accommodations for the acutely ill, injured, or those in need of elective procedures will be reserved.

It is your Reference Committee's understanding that this subject is under active consideration by the Council on Medical Service. Your Committee accordingly recommends that this matter be referred to the Council for appropriate action.

Adopted

IX. Legal Opinion by AMA Counsel

Your Reference Committee was greatly impressed by the candid, forthright presentation by Mr. A. Leslie Hodson, legal counsel for the American Medical Association. We believe that his remarks should be made available to all constituent associations for their information and study. We believe that this will engender a better understanding of the legal limitations which face all medical organizations and the medical profession. Your Reference Committee recommends that the remarks of Mr. Hodson be distributed to the constituent associations.

The House instructed the Board of Trustees to implement this action at the earliest possible date.

X. Non-Discrimination Under Federally Assisted Health Care Programs

Witnesses testified that a number of state agencies require pledges of non-discrimination for the ostensible purpose of meeting the requirements of title VI of the Civil Rights Act. Comments received were justifiably bitter in view of the profession's record of non-discrimination in patient care.

Your Reference Committee has been informed that the Department of Health, Education, and Welfare has recognized the injustice of these state agency requirements and has recommended a substantial modification of this practice. Your Reference Committee believes that this matter should receive continuing surveillance.

Although the Reference Committee recommended that this subject be referred to the Board of Trustees for continuing study by the Association's Law Department, the House did not concur and, in response to a motion from the floor, adopted Resolution No. 1. (Resolution No. 1 attached.)

XI. Separation of Professional Fees and Hospital Charges

Mr. Speaker, we offer the following statement of policy for consideration by the House:

Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians. The American Medical Association intends to continue vigorously its efforts to prevent inclusion in the future of the professional services of any practicing physician in the hospital service portion of any health care legislation.

Adopted as Amended

Mr. Speaker, the policy statements herein presented to the House for its action are intended to respond to the specific problems placed before this Reference Committee. We are certain that more definitive statements on Public Law 89-97 will be adopted by this House as regulations are promulgated and as the program is implemented. But lest we be misunderstood, your Committee wishes to clearly emphasize that none of its recommendations should be construed as approval of Public Law 89-97, or in any way as acceptance of its philosophy.

Dr. James Z. Appel, in his remarks as President, told of his awareness of the problems before us. Dr. Appel spoke in his own behalf, but his comments reflect your Committee's feelings as well.

We congratulate him on his statesmanlike presentation, and we commend to each delegate the written transcript of his remarks.

Dr. Appel reminded us that, "Ours is a profession which must remain unified." "Ours is a profession which *must* remain unified," echoed many a speaker before your Reference Committee. These expressions of unity were voiced time and time again.

How shall we best maintain unity?

The Board of Trustees, in its report to this House, detailed in chronological order its efforts and experiences since the Annual Convention in June 1965. Your Committee heard many witnesses testify to the good work of the Board, to its devotion, and to its strength during these difficult times. To these unanimous expressions of confidence, your Committee adds its own. But we would not stop here. The leadership of the American Medical Association has been tested under fire. In difficult and crucial times, our officers and the Board have responded to legislative crises with courage and conviction. Years of withstanding the onslaught of the Medicare proponents did not weaken or lessen the determination of our officials.

The enactment of Public Law 89-97 would have come long before were it not for the leadership of our Board and Officers.

Nor should we fail to gratefully acknowledge the dedication, the inexhaustible effort, and the guidance provided by Dr. Blasingame and Dr. Howard, our Executive and Assistant Executive Vice Presidents.

We believe that the members of this House of Delegates would profit from a current report of the Association affairs, its programs, facilities, and personnel. Mr. Speaker, your Reference Committee recommends that Dr. Blasingame be invited to make such a presentation at the Clinical Meeting in Philadelphia.

Adopted

Mr. Speaker, before closing this report, your Committee would acknowledge some additional testimony received during the course of its hearing. Some speakers complained of inadequate knowledge of the activities of the Board, Councils and Committees of the Association. We believe that wherever the fault may be found, it must be shared by many. Undoubtedly, the Association should strive to continue to improve all means of communication available to it so that each physician member will be kept well informed on important matters. But each physician must be willing to receive the information beamed his way—through news releases, the weekly *AMA News*, and other AMA journals, publications, and communications. Finally, some of the fault must be shared by those state societies, or local medical societies, who at times receive the news from the AMA but fail to relay it to their members.

In Resolution No. 3 and in other remarks of witnesses, the Board and the House of Delegates were asked to consider the need for long-range planning. Your Committee believes that planning for the future should be an integral part of the activities of each AMA Council and Committee, as well as of the

Board. While we realize that planning is a continuing and ongoing program in the AMA, we would urge that the Board of Trustees take steps to assure that efforts in this regard be stressed even more by the Councils and Committees. Society is in constant flux and the American Medical Association must be prepared to meet the challenge of our times.

In still other remarks, the need for active physician participation in political activity remains clear. Your Reference Committee recommends that the House urge constituent medical societies and physicians to support and assist AMPAC and local medical political action committees in their efforts to elect candidates to office who will help preserve the physician's right to the free and independent practice of medicine.

In conclusion, Mr. Speaker, the members of your Reference Committee have been privileged to act in the capacity assigned to them. We know that in these trying times, the physicians of America will stand together and serve together in the best interests of their patients.

As a point of personal privilege, Mr. Speaker, I wish to express my gratitude to each member of the Committee for his patience, and for his diligent effort in discharging the monumental task assigned to him.

Submitted by:

George J. Lawrence, Jr., M.D., New York
George W. Petznick, M.D., Ohio
Harvey Renger, M.D., Texas
John M. Rumsey, M.D., California
B. E. Montgomery, M.D., Illinois, Chairman

* * * * * * *

OTHER HOUSE ACTION

The House recommended that tape recordings of Dr. Edward Annis' presentation before the National Orientation meeting held October 1, 1965, be made available to any member of the Association upon request at a cost basis (to be paid by person requesting tape).

BAUER AMENDMENT

ADOPTED—A-61

The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachments by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay, and it further believes that the profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which we believe to be detrimental to the public welfare.

NINE PRINCIPLES FOR STANDARDS OF HEALTH CARE PROGRAMS

ADOPTED—S-65

(1) No person needing health care shall be denied such care because of the inability to pay for it.
(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.
(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.
(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.
(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.
(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.
(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.
(8) Any such health care programs should provide funds only, and not direct services.
(9) Funds for such programs may come from general tax revenues and not from social security taxes.

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Introduced by: Ohio Delegation
Subject: Pledge of Non-Discrimination
Resolution: 1
(S/2-65)

Whereas, The Department of Health, Education and Welfare has attempted to force physicians treating patients under federally-assisted programs to sign pledges of non-discrimination; and

Whereas, Physicians, by subscribing to the Principles of Medical Ethics, willingly pledge to render service unconditionally to all patients with full respect for the dignity of man, providing for each a full measure of service and devotion, including in time of war the provision of medical care to the captured enemies of our country; and

Whereas, These conditions willingly self-imposed by the medical profession far exceed any pledge of this nature demanded by a Federal bureaucracy; therefore be it

Resolved, That all physicians are hereby informed that the refusal to sign such an oath does not flout the law; and be it further

Resolved, That the House of Delegates directs the Board of Trustees and the Officers of this Association to oppose actively and forcefully this and any future attempts by HEW or any other Federal agency to impose conditions and pledges upon the medical profession.

CLINICAL SESSION, NOV. 28-DEC. 1, 1965

As was to be expected, Public Law 89-97 (Medicare) was one of the most discussed items at the AMA's clinical session, held in Philadelphia from November 28 through December 1, 1965. While there were many resolutions introduced calling for some changes in the law presently on the books, the House did adopt a resolution commending Arthur Hess, head of the Social Security Administration's Bureau of Health Insurance for his "wholehearted cooperation" with the AMA's advisory and technical committees on Medicare.

James Z. Appel, AMA president, in his opening remarks to the House of Delegates, described medicine's efforts "to guide in the best possible direction the actions that government agencies are now taking to activate existing law (Medicare)." In reviewing the activities of the various technical and advisory committees, Dr. Appel stated: "Their suggestions have been received favorably in most instances, and we are hopeful that they will be translated into the final published regulations . . . (but) we know that in certain significant instances this will not be true." Dr. Appel's remarks have been published in full in the December 6, 1965, issue of the *AMA News*.

In other actions of importance, the House established:

"Usual and Customary" and Prevailing Fees

One of the most controversial issues before the House and the Reference Committee on Insurance and Medical Service was the "usual and customary" fee concept and

the prevailing fees program of the National Association of Blue Shield Plans (NABSP).

The House reaffirmed its support of the "usual and customary" fee concept as the basis for reimbursing physician participants in government programs at all levels of government. It also urged "the individual physician's usual and customary fee concept to all third parties."

It took this action after modifying a Board of Trustees' report on the new "prevailing fees" program of NABSP. The modified report recommended:

> That the concept of the prevailing fees program of the NABSP be noted as one of the methods of compensation in those regions where the prevailing fees program is approved by the local or state medical society.

In its report, the Board recalled a statement adopted by the House at the 1965 Annual Convention, which recommended that when government assumes financial responsibility for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. "Therefore, reimbursement for the services of physicians participating in government-supported programs should be on the basis of 'usual and customary' fees," the statement said.

Abortion and Sterilization

Recommendations for the enactment of legislation to legalize abortion and sterilization under certain conditions were referred to the Board for further study. This action was taken after the House had received a report from the Board containing the recommendations of the Committee on Human Reproduction.

The House did suggest that the AMA can "render a distinct public service in this matter by conferring with other interested groups such as lawyers, clergy, sociologists, legislators, and government administrators."

It concurred in the reference committee's report that:

> It is not appropriate at this time for the AMA to recommend the enactment of legislation in this matter (abortion) for all states. The problem is essentially one for resolution by each state through action of its own legislature.

The report also stated:

> It is true that there are medical implications in such legislative decisions; physicians in each state should freely provide information and guidance on these medical implications. However, enacting laws to integrate the medical aspects with the moral, ethical, religious, economic, social tradition, and other aspects of the problem is clearly the exclusive prerogative and the responsibility of the legislature of each separate state.

In its report the committee said the problems of sterilization "appear subject to the same general considerations as the problems of abortion."

On the problem of contraception, the House reaffirmed its 1964 policy statement that:

> The prescription of child-spacing measures should be available to all patients who require them, consistent with their creed and mores, whether they obtain their medical care through private physicians or tax or community-supported health services.

It also endorsed a statement that:

> Appropriate legislation be enacted, wherever necessary, so that all physicians may legally give contraceptive information to their patients, consistent with the policy statement of December, 1964, and with the judgment and conscience of each individual physician.

Billing and Payment for Medical Services

Eight statements on fees charged by physicians for medical services were affirmed by the House. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated. Here are the eight statements:

1. The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.

2. It is the patient's responsibility to deal with third party carriers in the area of financial assistance provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.

3. The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees and the physician directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

4. The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

5. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

6. It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. (The foregoing is from a report of the Council on Medical Service to the House of Delegates at the Clinical Meeting in 1954).

7. The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960).

8. It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958).

Gundersen Report

The House approved some of the many recommendations of the Committee to Review the Organization of the House (the Gundersen Committee), but it did not approve a number of others. Here are the House actions on some of the committee's recommendations:

Size of the House of Delegates.—Approved the suggestion that the growth of the AMA House be slowed down after it reaches 250 members. When it reaches that size, the apportionment ratio will be automatically raised from one delegate per 1,000 members, or fraction thereof, to one delegate per 1,250 members, or fraction thereof, in electing further delegates to represent each state association.

Reports of Councils and Committees.—Rejected the proposal that reports of the Council on Medical Service and Medical Education be transmitted through the Board of Trustees before being presented to the House.

Reference Committees.—Adopted the recommendation that there be three reference committees by name: Amendments to Constitution and Bylaws, Credentials, and Rules and Order of Business, and as many others be appointed "as may be required to consider the items of business before the House."

Tenure of Subcommittee Members of Standing Committee.—Approved a change in the Bylaws "to limit to specified terms of one to three years the tenure of members of special committees of the councils and committees of the House, with a limitation of 10 consecutive years of service."

Committee on Medical Practices.—Concurred in a recommendation that the Committee on Medical Practices be discharged with thanks and its responsibilities "be assigned by the Board to existing councils and committees."

Committee on Insurance and Prepayment Plans.—Rejected a plan to make this committee a council of the Board, and the committee was retained under the Council on Medical Service.

Tenure of Office of Trustees.—Turned down a proposal that would have affected the tenure of office of AMA trustees.

Affairs of Standing Committees.—Directed that a Bylaws change be prepared to remove the privilege of the Councils on Medical Service and on Medical Education of nominating to the Board the Secretary of the respective council. Also approved the suggestion that a vice chairman be elected by each standing committee of the House.

Resolutions to House.—Rejected the idea of a resolutions expediting committee and the recommendation that the deadline for resolutions be 10 days prior to the House meeting.

Federal Health Care Laws

The House took a number of actions with regard to federal health care laws passed in 1965, such as PL 89-97 (Medicare) and PL 89-239 (the Heart Disease, Cancer, and Stroke Amendments).

These actions included:

1) That the AMA immediately seek remedial action to delete the requirement in Public Law 89-97 that a patient be hospitalized to establish eligibility for nursing home care.

2) That the AMA immediately seek remedial action to amend Public Law 89-97, Part B, Title XVIII, by deleting the word "receipted," from Section 1842, Part 3, Item B, line (ii), and substituting "such payment will be made on the basis of a method of payment so arranged to preserve and continue the professions current practice of billing." Also approved "that the AMA recommend that the Department of Health, Education and Welfare establish that an agreement for payment between the patient and physician constitutes valid evidence of services rendered."

3) Authorized a study of the constitutionality of PL 89-97 by calling on the Board to "take such action as may be necessary and appropriate to provide for the study and investigation of all aspects of PL 98-97 for the purpose of determining possible court action to test the legality and constitutionality of any provision or regulation issued under the law," and authorized the Board to "initiate such legal proceedings as it may deem advisable to implement the purpose and intent of this resolution."

4) Endorsed the Council on Medical Services' recommendation "that the state and local medical societies be urged *at this time* to assume leadership in the establishment of local advisory committees" under the Heart Disease, Cancer, and Stroke amendments of 1965. The House noted that a National Advisory Council under PL 89-239 already has been appointed by federal officials and that the AMA was not given an opportunity to recommend possible appointees to the Council. "Therefore," the House declared, "active physician participation at the state and local levels is of utmost importance."

5) Urged HEW to "seek consultation with practicing physicians" in formulating regulations under Title XIX as has been done under Title XVIII of the Medicare law. It also instructed the AMA President and AMA Advisory Committee to HEW to "offer and urge such consultation."

6) Adopted a resolution that the Board:

> Continue to seek, through all appropriate means, the implementation and administration of federal medical and health programs other than those of the Armed Forces and Veterans' Administration by the Surgeon General of the Public Health Service, and especially those programs under Title XIX of PL 89-97.

7) Declared that the AMA Advisory Committee on PL 89-97 and 89-239 should persist in its efforts to achieve "practical recognition" by HEW of the differences between utilization review and claims review. The House adopted a report of the Council on Medical Service which said that "widespread confusion exists between the utilization review function and the claims review function." It also adopted a series of recommendations in the report aimed at clearing the confusion.

Other Important Actions

A study committee to evaluate planning techniques and development, which was established by the Board of Trustees, was concurred in by the House. The committee was given the tasks of 1) reviewing and studying current planning procedures in AMA, and 2) studying and recommending new mechanisms for organizational arrangements to achieve more effective planning and development in the future. Membership on the committee includes five Board members, the chairmen of the Councils on Medical Service, Medical Education, and Legislative Activities, the Speaker of the House, and two House members selected by the Speaker.

Disapproval was expressed by the House of portions of the Coggeshall report, "Planning for Medical Progress Through Education," published earlier this year by the Association of American Medical Colleges. The House opposed "the basic philosophy" of portions of the report, such as:

1) That the AAMC should "serve as spokesman for organizations concerned with education for health and medical sciences" and "no other organization is in a comparable position to bring together and express a comprehensive view."

2) That "the professional aspects of education for health and medical sciences should be regarded as an essential function and fully integrated component of university organization, with decreasing dependence upon or control by organized professions and their related associations."

A policy statement on federal aid to medical education was adopted by the House. It urges that 1) a major objective of the policies of the AMA should be to place the control of the full range of medical school functions in their institutional governing bodies, 2) action of the AMA should be designed to achieve this objective by proposal of appropriate legislation, and 3) the AMA should foster diverse sources of support for medical schools under circumstances that prevent any extramural source from exercising controlling influence.

The House approved a resolution aimed at responding immediately at the national and local levels to statements discrediting medicine. It directed the Board to provide for such response by the AMA and encouraged state and local medical societies to react similarly to statements appearing at the local level and concerning matters within the society's competence and knowledge.

There were scores of other actions by the House. Briefly here are some of them:

1) Defeated a proposal to set more stringent requirements for calling a special session of the House.

2) Approved a Bylaws change permitting recognition by affiliate AMA membership of physicians "who are members of the chartered national medical societies of foreign countries, to be approved and nominated by the Judicial Council" and members of the press who have served medicine well.

3) Approved a resolution calling for continued efforts, through "all appropriate channels," to achieve a separation of billing and payments for professional fees from hospital charges under insurance contracts written by the health insurance industry.

4) Urged the American Hospital Association to "assist the hospitals of the U. S. to establish a system of uniform cost accounting and billing."

5) Asked that all colleges and universities should have health education programs for their students.

6) Commended physicians in government service for "their support of the medical profession and their service to the public."

7) Agreed to a rewriting of two sections of a model agreement between hospitals and physicians providing professional services in hospital emergency departments to conform to principles established by the House.

8) Approved measures aimed at decreasing substantially the perinatal death rate through perinatal study committees in hospitals.

9) Requested state medical associations to act to assure that physicians are properly represented on state Hill-Burton hospital advisory councils.

10) Asked the Federal Aviation Agency to change its regulations so that any person applying for a pilot's license would be giving his implied consent to sobriety examinations by aviation officials.

11) Decided that AMA conventions should continue to open on Sunday and that the inauguration of the incoming president should be held on Tuesday evening of the Annual Convention.

12) Instructed the Council on Medical Service and its Committee on Welfare Services to develop for the AMA its definition and principles for the determination of medical indigency.

13) Accepted for information an opinion adopted jointly by the Council on Medical Service and the Judicial Council which states that:

> . . . when a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction and supervision.

14) Repeated a previous policy statement urging the creation of a separate post in the cabinet of the President of the United States for a Secretary of Health.

15) Commended past president Edward R. Annis, M.D., for his leadership, his dedication, and his tremendous contribution to medicine's campaign to preserve the world's finest system of medical care.

16) Elevated to status of Council the Committee on Environmental and Public Health.

As part of the session, contributions made by individual members of the profession to American Medical Education and Research Foundation were presented to the Foundation before the assembled members of the House. Maryland's contribution of $9,605 was made by Robert vanL. Campbell, M.D., senior delegate and president of the Faculty.

Respectfully submitted,

Robert vL. Campbell, M.D.
J. Sheldon Eastland, M.D.
Russell S. Fisher, M.D.
William B. Hagan, M.D., alternate

ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

During the past year, the Med-Chi Insurance Trust was established and approved by the House of Delegates in September, 1965. The program is well organized and underway, and we look forward to an effective increase in types of insurance offered to our members and to improvements in current insurance programs. Beginning in 1967, the Med-Chi Insurance Trust will make an annual report to the House.

The Health Insurance Review Subcommittee reviewed nine cases of fee disagreement between major medical insurance carriers and physicians. It is the responsibility of the subcommittee to ensure that such carriers are obligated to pay 80% of the customary fee for the same procedure as is usually charged in the community. Decisions of the subcommittee have fallen into a rough pattern of approximately 66⅔% in favor of the physicians.

U. S. Armed Forces Dependents Medical Care Program

Payments through Blue Shield and Blue Cross to physicians and hospitals in Maryland for care rendered to dependents of active duty military personnel totaled $733,922 during 1965. Of this amount, payments for physicians' services amounted to $301,059 and hospital payments were $432,863. These amounts compare with $314,158 and $458,353, respectively, in 1964.

During the year the Blue Shield Dependents Medical Care Section processed claims for 4,201 physicians' services. Table 1 shows the distribution of these claims by type of care.

TABLE 1
PAYMENTS TO PHYSICIANS

Type of Service	Number	Percentage	Amount	Percentage	Average Payment per Service
TOTAL	4,201	100.0	$301,058.60	100.0	$ 71.66
Obstetrical	1,584	37.7	191,308.19	63.5	120.77
Surgical	521	12.4	49,883.25	16.5	95.74
Medical	934	22.2	34,531.66	11.4	36.97
Other	1,162	27.7	25,335.50	8.6	21.80

Since the beginning of the program in 1956, maternity care has consistently accounted for the major segment of total care; this pattern was maintained in 1965 with expenditures for physicians' services. Obviously, the reason for this pattern is the much younger average age of those covered by the program. Surgery accounted for 16.5%, medical benefits for 11.4%, and miscellaneous other services (anesthesiology, radiology, etc.) comprised the remaining 9.6% of payments.

The Advisory Committee for the Dependents Medical Care Program, a group of physicians appointed by the Medical and Chirurgical Faculty as a subcommittee of the Economics Committee, continued to help in the administration of the program, although less demand had to be made on their time than in previous years. The committee acts as an adjudicating body in cases requiring professional judgment and advises the fiscal agent in matters pertaining to professional practice. During 1965 the committee met on two occasions and acted upon 27 specific cases referred to it at the request of individual physicians or the staff of the Maryland Blue Shield Plan, the fiscal agent. Table 2 shows the distribution of committee cases by type of care.

TABLE 2
DISTRIBUTION OF COMMITTEE CASES BY TYPE OF CARE

General surgery	9
Obstetrics and gynecology	8
Medical	3
Plastic surgery	2
Anesthesia	2
Pediatrics	2
Psychiatry	1

The hospitals of Maryland provided a total of 12,404 days of hospital care to the dependents of servicemen incidental to 2,281 admissions in 1965. The average length of stay per admission was 5.43 days and the average cost per case, $189.76.

During 1965 the Maryland Blue Shield Plan continued to act as fiscal agent for the Faculty in administering the Dependents Medical Care Program in Maryland. The Plan was reimbursed by the Federal government for claims paid and actual administrative costs in connection therewith.

Respectfully submitted,
Paul F. Guerin, MD, chairman
William B. Settle, MD, vice chairman
Arthur Baitch, MD
Gilbert L. Banfield, MD
Edward M. Barczak, MD
Harry J. Connolly, MD
Eugene D. Lyon, DDS
Alfred S. Norton, MD
Hugh W. Ward, MD
Eldridge H. Wolff, MD

INSURANCE, SUBCOMMITTEE: Harry J. Connolly, M.D., chairman, William B. Settle, M.D., vice chairman; A. Talbott Brice, M.D., William H. Mosberg, Jr., M.D., Alfred S. Norton, M.D., Edwin M. Ruzicka, M.D., William N. Thomas, M.D., John F. Strahan, M.D.

HEALTH INSURANCE REVIEW SUBCOMMITTEE: William B. Settle, M.D., chairman, Robert G. Chambers, M.D., Charles P. Crimy, M.D., Frank W. Davis, Jr., M.D., Gerald A. Galvin, M.D., Julius M Waghelstein, M.D.

MEDICARE SUBCOMMITTEE: Wilson Grubb, M.D., chairman, Barnett Berman, M.D., Emil Blair, M.D., Katherine H. Borkovich, M.D., C. Holmes Boyd, M.D., Gordon Cader, M.D., Ernest I. Cornbrooks, M.D., W. Bowdoin Davis, M.D., Lawrence N. D'Elia, Jr., M.D., Liebe S. Diamond, M.D., William D. Gentry, Jr., M.D., M. Reza Hagigh, M.D., Benjamin Highstein, M.D., Claude D. Hill, M.D., Robert W. Johnson, 3rd, M.D., Louis F. Klimes, M.D., Abraham M. Kremen, M.D., Eugene J. Linberg, M.D., Deonis M. Lupo, M.D., J. Nelson McKay, M.D., Ross Z. Pierpont, M.D., Albert Weiss, M.D.

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

This committee has concentrated on three main areas: legislation, education of physicians in mental health, and inclusion of psychiatric services in general hospitals.

The Patient/Psychiatrist Privileged Communication bill, which was vetoed by the Governor in 1965, was again introduced in 1966. The Governor, in his veto message, indicated that if it were passed again by the Legislature and agreement were reached with the psychologists and lawyers, he would sign it into law. Minor concessions were made to the psychologists in the 1966 bill, but no agreement could be reached with the legal profession. The members of the committee have worked assiduously for the enactment of this much needed legislation, which is now being studied by the Senate Judiciary Committee.

The Community Mental Health Services Act, now being discussed by the Senate Finance Committee, is the result of collaboration and compromise among all interested groups. The committee believes that although this legislation is not written in its most desirable form, the idea it advances commands the support of the practicing physicians in Maryland. The fate of this act is still in doubt but is being watched carefully by this committee.

Some advances have been made by the Subcommittee on Education. Although definite dates have not been arranged, commitments have been received from two component societies for program presentations. Plans have also been made to produce two programs on the MEDIC network, one on June 3 and another in September. This progress is due mainly to the personal efforts of the previous subcommittee chairman, Anthony S. Garofano, MD, and his successor, Thurman Mott, Jr., MD, both of whom are to be congratulated for their successes and thanked for their endeavors.

Another area of effort has been the furthering of psychiatric services in general hospitals. A tour of the Prince George's General Hospital psychiatric unit was conducted for administrators of general hospitals throughout the state. This tour impressed on those attending that a general hospital can incorporate a psychiatric service without disturbing other areas of care. The Faculty Council, at the request of this committee, endorsed a statement which reads in part as follows: "The Medical and Chirurgical Faculty of the State of Maryland heartily supports the inclusion of psychiatric services, both inpatient and outpatient care, in all general hospitals in the State of Maryland." This lends authority to the activities of the committee and has been publicized in the *Maryland State Medical Journal.*

In order to promote this concept, the Education and Training Committee of the Advisory Council on Mental Hygiene has been requested to study plans for the inclusion of general hospital training in the educational programs of the state mental hospitals.

The Faculty, through this committee, cosponsored a Mental Health Planning Conference, held during the past year. This was well attended by both physicians and members of ancillary groups.

A member of the Faculty staff and the Chairman attended the 12th Annual Conference of State Mental Health Representatives in March, 1966. Since the sections of the country are so widely separated in their care and attitude toward mental health, it has been decided that more could be gained from having small regional meetings in the future rather than the national one. Maryland has been grouped with Delaware, New Jersey, New York, and Pennsylvania, at the request of this committee. Much can be learned from meetings with the mental health leaders in these states.

Although the committee has suffered several setbacks in its ambitions, encouraging advances have been made, too. It is the consensus of the committee that the basis for future success in several areas has been formed and will be of immeasurable value in the coming year.

Respectfully submitted,
Augusto J. Esquibel, MD, chairman
Irvin H. Cohen, MD
William H. Edwards, MD
Anthony S. Garofano, MD
John Lertora, MD
Thurman Mott, Jr., MD
Richard H. Pembroke, Jr., MD
William J. Peeples, MD
Jonas R. Rappeport, MD
Kent E. Robinson, MD
Isadore Tuerk, MD

SUBCOMMITTEE ON EDUCATION: Thurman Mott, Jr., M.D.

FEE SCHEDULE COMMITTEE

Mr. President and Members of the House of Delegates:

After many hours of work on the part of the Fee Schedule Committee, a guide for the fee for service to semiprivate patients in the $7,500 or under income level was developed and presented to the Council in November, 1965. The Council formally adopted this in January, 1966, with the understanding that adjustments should be made when required by changing circumstances. Copies were mailed to all *active* members on March 4, 1966.

Many items are still pending before the committee. Questions must be answered or recommendations made to the Council on matters such as presenting this or another schedule to the Workmen's Compensation Commission for approval, development of a home and office service and procedure schedule, and working with the State Health Department in its program of payment of "usual and customary" fees for patients under the indigent and medically indigent care programs.

It should be emphasized that semiprivate fees for in-hospital services represent, in most instances, a reduction in the physicians' usual and customary fees and therefore should apply only when the patient is directly responsible for the fee or when services are rendered under an income limitation schedule.

Certain matters now under active discussion in the committee may require a supplemental verbal report to the House of Delegates, and it would be appreciated if this can be arranged at an appropriate time.

Respectfully submitted,

William G. Speed, III, MD, chairman
Katherine H. Borkovich, MD
Archie Robert Cohen, MD
Charles N. Davidson, MD
John R. Davis, MD
George H. Greenstein, MD
Wilson Grubb, MD
Richard E. Hoover, MD
Watson P. Kime, MD
Alfred T. Lieberman, MD
Howard B. Mays, MD
John E. Miller, MD
Frank K. Morris, MD
Alfred T. Nelson, MD
William B. Settle, MD
Lex B. Smith, MD
Israel Zeligman, MD

General Practitioners by Districts:

Leon W. Berube, MD (Southern)
Ernest A. Dettbarn, MD (Western)
Edward G. Grau, MD (Central)
Andrew C. Mitchell, MD (Eastern)
Wolcott L. Etienne, MD (S. Central)

At Large:

John W. Ashworth, MD
John Hornbaker, MD
Robert W. Johnson, 3rd, MD
Samuel Friedmann, DDS
William H. Mosberg, Jr., MD
William L. Stewart, MD

AD HOC FINANCE COMMITTEE

Mr. President and Members of the House of Delegates:

An Ad Hoc Committee on Finance was formed and charged with specific financial responsibilities after the 1965 Annual Meeting, upon recommendation of the previous treasurer. The Ad Hoc Committee was set up to see if there were sufficient matters to warrant appointment of a standing committee.

Since that time, the Ad Hoc Finance Committee has made a recommendation that it become permanent, and the Bylaws Committee has prepared Bylaw changes to accomplish this. They are presented in the Bylaws Committee report.

In June, 1965, the Council approved the following recommendations of this committee, and they have been working out satisfactorily:

1. Provide for regular reports to the Council on the financial status of Faculty finances, including designated funds. This would be done at the regular Council meetings.
2. Establish a separate payroll account on an imprest basis subject to a single signature, either the Executive Secretary or the Treasurer.
3. Amend signature procedures on the general fund checking account so that bills up to $500 may be paid over the signature of either the Executive Secretary or the Treasurer. It would be Faculty policy that any checks over $500 in value would be signed by the Treasurer only.
4. Approve deposit of all cash receipts to the Faculty's savings account where they would be invested in short-term investments maturing as the funds are needed for Faculty operations. Withdrawals from this savings account would be on the signature of the Treasurer only.
5. On a monthly basis checks would be drawn on the savings account, to be signed by the Treasurer only, replacing money used from the payroll imprest fund

and the general fund imprest account. A complete accounting of the funds spent during the month would accompany each withdrawal check.

6. Continue to evaluate the accounting and bookkeeping operations of the Faculty so as to simplify and modernize them as much as possible.

A supplemental verbal report may be made to the House of Delegates if data are available and on which the committee may formulate some conclusions.

Respectfully submitted,
KARL F. MECH, MD, chairman
WILLIAM A. PILLSBURY, MD
J. MORRIS REESE, MD
E. W. DITTO, JR., MD

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Legislative Committee held several meetings during the past year. We met once before the State Legislature convened and again during the session to outline our course of strategy. This procedure has worked extremely well. We have been assisted by many of our friends in allied health fields, and we are most grateful.

During the 1966 Legislative Assembly, 131 bills were introduced in the House and 53 bills in the Senate, all of which have some medical connotation. Careful scrutiny of these bills and watchfulness while they were pending in the various legislative committees has resulted in the passage of bills which are helpful to the public.

We find in our discussions in Annapolis that legislators are anxious and willing to receive advice from the profession. We believe that action on a component society level will assist both the profession and the legislators to become aware of the pitfalls that preparing and introducing health legislation can create. In every instance, suggestions offered by the Faculty's representatives in Annapolis for amendments to bills were accepted by either the sponsors or the committees in which hearings were held on such bills.

Major bills of consequence and their final status is as follows:

SENATE BILLS

Senate Bill 118.—This bill, introduced by the Maryland Psychiatric Association and other interested parties, was supported by the Faculty. It provided for "privilege" for psychologists and psychiatrists except in certain instances.

It had a stormy hearing in the Senate Judiciary Proceedings, was amended and reported out favorably with amendments to the Senate. It passed the House in the last legislative session day. It now awaits signature by the Governor. Last year, a similar bill was vetoed by the Governor, a fate that may happen again, though it is doubtful.

Senate Bill 143.—To permit the Board of Medical Examiners to suspend, as well as place on probation, the licenses of physicians who are called before the Board. The Board had only the power to revoke.

The bill was introduced through Faculty sponsorship and passed both houses without any changes. It awaits signature by the Governor.

Senate Bill 150.—To amend the battered child laws to require others who see children with this syndrome to report these cases to the local welfare department for investigation; to provide civil immunity for those making such reports; and to set up a central registry for such cases in the State Department of Social Welfare.

This bill was introduced through sponsorship of the Faculty and other interested groups. It passed both houses without any substantial change and awaits signature by the Governor.

Senate Bill 270.—To provide for an increase in the amounts paid medical examiners by local governments. This bill was supported by the Faculty and passed both houses without difficulty. It awaits signature by the Governor.

Other bills in which the Faculty was interested include:

Senate Bill 46.—To provide for a change in the insurance laws making it unnecessary for individuals to report possible lawsuits for alleged negligence. This passed.

Senate Bill 60.—Implied consent laws. After amendment in the Senate and further amendment in the House, it failed in conference committee and is dead until the next legislative session.

Senate Bill 61.—Making abortions in cases of rape and carnal knowledge legal, provided the local state's attorney certifies as to the authenticity of the case. This passed.

Senate Bill 325.—Requiring state agencies and other local government agencies to accept reports of optometrists in any matters with which they are concerned and within the scope of the practice of optometry. This passed both houses and awaits signature by the Governor. An attempt is being made to have a hearing befor the Governor in the hopes that this undesirable legislation can be vetoed.

HOUSE BILLS

The Faculty had no specific interest in introduction of various bills in the House except in the manner in which they might affect the health of Marylanders. A partial summary of bills and the Faculty's stand follows:

House Bill 277.—This would have required physicians to provide a certificate or statement to patients that they are unable to drive a motor vehicle, if the physician so thought. Such statements or certificates would have to be sent in with every third renewal for patients over 40; every other renewal for patients over 50; and every renewal for patients over 60. The Faculty opposed this and suggested instead a partial list of diseases or conditions which would be automatically reportable by physicians when patients presented themselves for care.

Neither of these bills was adopted, and this matter continues under study for some type of legislative suggestion in 1967.

House Bill 269.—To provide for license suspension for individuals driving while under the influence of barbiturates and/or amphetamines, as well as alcohol and narcotics. This bill passed.

House Bill 327.—To permit addicts to be released to an authorized aftercare program rather than being sentenced

to prison. The Faculty supported this proposal, and it was enacted into law.

House Bill 328.—To increase the penalties and amend the law to make it a crime to have possession of barbiturate and/or amphetamines except in the normal course of business, occupation, profession, etc. There was no exception in the original bill, but conference with the sponsors added the exemption noted. This bill passed.

House Bill 361.—This bill increased the size of the Board of Physical Therapy to add two physical therapists to the current Board of five physicians. All persons will be named by the Governor from lists submitted by the Faculty. The Faculty supported this bill, and it was enacted.

House Bill 487.—Known as the osteopathy bill, this would have given osteopaths full rights and privileges to practice allopathic medicine. The Faculty waged an all-out fight to ensure that it was killed in the House Ways and Means Committee, and the bill was defeated by a 30-5 vote.

House Bill 544.—This was a Humane Society proposal requiring record keeping and licensing and inspection of animal facilities. It did not exempt research laboratories. It passed the House but was held in the Senate committee.

House Bill 675.—This Health Department proposal ran into difficulties after it passed the House with an amendment. The original bill required the Health Department to establish minimum rules and requirements for laboratories and issue permits for them. The Faculty sponsored amendments that would require out-of-state laboratories to meet the same requirements as laboratories in Maryland and would prohibit solicitation or advertising by all such laboratories.

With deadline for adjournment of the General Assembly, the Senate Judicial Proceedings Committee amended the House-passed version and, at the last session of the House, the amendments were concurred in and the amended bill was enacted.

House Bill 1010.—This bill would have required all insurance carriers to offer policies which included payment for chiropractic services. The decision to accept or reject would be with the public. This bill passed the House but died in the Senate Insurance and Banking Committee.

A complete listing and breakdown of all bills with which the profession is concerned can be found in *The Assemblyman,* published during the legislative session.

Federal Legislation

With the passage of Medicare legislation, PL 89-97, in the summer of 1965, legislative attention on a federal level was turned to such items as animal care facilities, Hart Bill (making it illegal for a physician to dispense drugs, eyeglasses, etc.), and other similar items.

During the early part of 1966, the committee met with other health groups and representatives of Congress. Congressmen Friedel and Fallon both joined the meeting in person. An enjoyable evening was spent in becoming better acquainted with our representatives in Washington.

The first objective of our meeting was to acquaint them with the assistance that the physicians, dentists, nurses, hospital representatives, and others can be to them in many ways, not only in helping them to answer their constituents' queries but also in helping them with any problems of medical import. We believe these meetings are fruitful and plan to continue them at least once a year.

Our thanks go to all those individual members who assisted us in contacting their delegates or senators. Without their help, our work could not have been accomplished as successfully as it was.

Respectfully submitted,
B. Martin Middleton, chairman
I. Rivers Hanson, MD
Karl F. Mech, MD
Eugene L. Passagno, DDS
Belden R. Reap, MD LL B
Mrs. Robert A. Reiter
Lester Kiefer, MD, (Allegany Co.)
Philip Briscoe, MD (Anne Arundel Co.)
Jonas R. Rappeport, MD (Baltimore Co.)
Philip W. Mercer, MD (Carroll Co.)
Seymour Goldgraben, MD (Cecil Co.)
Eugene Traub, MD (Dorchester Co.)
Robert J. Thomas, MD (Frederick Co.)
E. I. Baumgartner, MD (Garrett Co.)
Thomas F. Herbert, MD (Howard Co.)
Arthur T. Keefe, Jr., MD (Kent Co.)
Leon R. Levitsky, MD, (Prince George's Co.)
Jack H. Beachley, MD (Washington Co.)
Charles W. Trader, MD (Worcester Co.)

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

The entire committee met three times during the past year, and its subcommittees met at various times.

The Liaison Committee, through its Subcommittee on Nursing, has recommended certain policies which have been endorsed by the Council and Executive Committee. These policies related to the following: 1) protocol on registered nurse responsibilities in relation to the Medical Practice Act; 2) closed chest resuscitation and artificial respiration by the registered nurse; 3) intravenous administration of fluids, blood, medications by registered professional nurses practicing in Maryland. Copies of these policies are available through the Faculty office.

Pharmacy Liaison Subcommittee—This subcommittee has continued to cooperate with representatives of the Maryland Pharmaceutical Society and has provided speakers for its annual meeting. Plans are underway for a proposed code of cooperation with the pharmacists and for a series of articles dealing with pharmacy and medicine.

Another item of business, although no conclusions were reached, is that of volume discounts offered by drug manufacturers to the State Health Department for prescriptions written by physicians under the Medical Care program. Such discounts would be paid directly to the state and would be based on the total volume of drugs used in state agencies during any given year.

The chairman met with the secretary of the Maryland State Board of Pharmacy Examiners to clarify certain areas in connection with the "Protocol on Registered Nurses Responsibilities in Relation to the Medical Practice Act." These points were amicably settled, and the Maryland Nurses Association advised accordingly.

Other Matters—The committee, through Edgar P. Williamson, III, M.D., has maintained continuous contact with various state agencies to let them know that the Faculty is available to assist in any areas it can. The State Education Department has asked for assistance in revising its bus drivers' physical examination form, and discussions will be continued in this area.

The State Health Department, in response to a query, advised that x-rays are not provided to any "special interest" groups. The committee approved suggested PKU rules and regulations, approved a proposed policy with respect to examinations being performed by State Health Department laboratories, developed a new communicable disease reporting form in cooperation with the Health Department's Division of Epidemiology, learned that tonometry testing by optometrists, using the scleral tonometry procedure is within the scope of the optometry law, and approved a recommendation of the Community Hospital Liaison Subcommittee that it be disbanded and reactivated later if necessary.

Pending items—Items still pending in the committee include liaison with the Health Department in connection with PL 89-239 (Heart Disease, Cancer and Stroke) and PL 89-97 (Medicare), as well as development of a compendium of rules and regulations with which physicians must comply.

Respectfully submitted,

John F. Schaefer, M.D., chairman
E. I. Baumgartner, M.D.
Melvin N. Borden, M.D.
Charles P. Crimy, M.D.
Robert E. Farber, M.D.
Gerson A. Freedman, D.D.S.
Paul F. Guerin, M.D.
J. Roy Guyther, M.D.
Claude D. Hill, M.D.
Ralph G. Hills, M.D.
Walter E. James, M.D.
Wm. J. McClafferty, M.D.
W. Kenneth Mansfield, M.D.
Wm. J. Peeples, M.D.
Theodore A. Schwartz, M.D.
Frederick J. Vollmer, M.D.
H. Leonard Warres, M.D.
John White, M.D.
Edgar P. Williamson, II, M.D.

LABORATORY SERVICES SUBCOMMITTEE: Frederick J. Vollmer, M.D., chairman, Wilbur N. Baumann, M.D., Robert L. Cavenaugh, M.D., William B. Culwell, M.D., John K. Frost, M.D., Paul F. Guerin, M.D., Claude D. Hill, M.D., Howard W. Jones, Jr., M.D., D. Frank Kaltreider, M.D., William H. Kammer, Jr., M.D.

MEDICO-RELIGIOUS SUBCOMMITTEE: Edgar P. Williamson, II, M.D., chairman, Melvin N. Borden, M.D., Frederick J. Vollmer, M.D.

NURSING LIAISON SUBCOMMITTEE: John F. Schaefer, M.D., chairman, Charles P. Crimy, M.D., W. Kenneth Mansfield, M.D., Ruth M. Moubray, R.N., Mrs. Eleanor A. Reese.

PHARMACY LIAISON SUBCOMMITTEE: John F. Schaefer, M.D., chairman, Mr. F. S. Ballassone, Mr. James P. Cragg, Jr., Mr. Nathan I. Gruz, Mr. Victor H. Morgenroth, Jr., Frederick J. Vollmer, M.D., Edgar P. Williamson, II, M.D.

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

In 1965 the library reinstated visits to county society meetings whenever possible. By this means, the library personnel can become aware of the actual needs of members outside the Baltimore area. At the same time, these Faculty members have a chance to examine a sampling of the new books in the library and to discuss their needs for new subject materials and request titles not in their own libraries. Three such visits were made last fall, and more are scheduled this year.

New shelving was added in the reading room, and a new 72-drawer walnut catalog case supplements the outgrown cabinets already in use. New chairs replaced some of the damaged older chairs in the reading room. An order desk was bought for the office, and a new conserva-file cabinet contains the vertical file materials. With a fresh paint job in the spring, the library quarters will show considerable improvement.

The sale of duplicate sets of *Index Medicus* and *The Quarterly Cumulative Index of Medicine* brought $1875, which will be applied to library expenses.

During the year, Mrs. Sanford attended an advisory group meeting on Information Needs of the Practicing Physician, called by the Scientific Activities Section, AMA, in Chicago, May 10, 1965. This seminar was planned by Mrs. Susan Crawford, director of the Archive-Library Department, and was attended by representatives from the National Library of Medicine, several outstanding university libraries, the president of the Medical Library Association, and eight medical society librarians. Its purpose was to determine exactly what the physician wants from his own professional library.

Both Mrs. Sanford and Mrs. Miller attended the Medical Library Association meeting in Philadelphia, where they participated in continuing education courses in library techniques and visited several Philadelphia libraries, particularly that of the American College of Physicians and the rare book collection at the Free Library of Philadelphia. Special Libraries Association met later in Philadelphia and was attended by Mrs. Sanford.

In October the Medical Library Association held a regional meeting in Charlottesville, Va, to discuss "Upgrading the Rundown Medical Library." This group will meet in Baltimore next fall with Welch Library as host. Our library will cooperate with arrangements.

In November our library was host to the Baltimore Hospital Librarians Association. Louis Krause, MD, was speaker. Mr. Alfred Brandon, president of the Medical Library Association, also spoke briefly about the Medical Library Assistance Act of 1965.

Library exhibits were present at the annual and semiannual meetings of the Faculty, with a librarian in attendance.

Some progress was made in rearranging the basement collection, but this project is not completed. Securing part-time library assistants to complete this project is a problem. About half of the collection which has been housed in the corridor has been moved to the enclosed stacks, where the volumes will be better protected from dust. These titles are being interfiled with titles in the main basement stacks. Corridor shelves will eventually be used for a duplicate collection of journals.

Requests for bibliographies have steadily increased. These are often excessively time consuming, even though the librarians try to maintain a tentative time limit and scope within the potential of the small professional staff. Statistics show only the bibliographies which are actually typed and entered into the bibliography file. Many shorter searches are accomplished which do not appear in this figure.

Interlibrary loans constitute a great part of the library activity, both charged out to other libraries and borrowed by this library. The Medical and Chirurgical Faculty Library borrowed 329 items from the National Library of Medicine and other libraries in 1965.

No memorial gifts were received during 1965.

The Rare Book Room situation remains the same as in 1964, there being no other available space for it.

The following statistics for 1965 show a healthy increase over the 1964 statistics:

Circulation	
Journals	3905
Books	1784
Total	5,689
Attendance	3,091
Courtesy cards issued	15
Bibliographies	188
Additions	
Bound journals added	507
Books added	391
Total	898
Total volumes	92,332
Gifts	
Journals	1,065
Books	82
Pamphlets, pictures, reprints, etc.	100
Total	1,247

Respectfully submitted,
Library and History Committee
Louis Krause, MD, chairman
H. Baldwin Streett, DDS
Katherine A. Chapman, MD
Robert B. Goldstein, MD
Paul F. Guerin, MD
Thomas C. Hill, MD
Finney Fund Committee
George G. Finney, MD, chairman
Richard G. Coblentz, MD
Richard W. TeLinde, MD
John P. Haberlin, MD
Richard V. Hauver, MD

MARYLAND JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGED

Mr. President and Members of the House of Delegates:

This organization was dissolved in June, 1965, and the money remaining in the bank balance has been prorated among the participating organizations.

Respectfully submitted,
Albert E. Goldstein, MD*
C. Rodney Layton, MD
John W. Clark, DDS, MD

*Deceased

MARYLAND MEDICAL SERVICE BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

In the past year Maryland Blue Shield set new records in enrollment, in benefits provided, and in operating efficiency.

More than 47,600 new members were enrolled during the year, bringing total membership under all types of certificates to 889,572 as of December 31, 1965. The gain of 5.7% in membership was more than twice the national average and reflects both the public's confidence in Maryland Blue Shield and the effectiveness of its sales efforts. Enrollment in Blue Cross increased by about 35,000 during the year, bringing the total to 1,188,204. At the end of the year Blue Shield enrollment was 75% that of Blue Cross, as compared with 72% the year before.

At the year's end, 83% of Blue Shield members were enrolled through groups, the remaining 17% being direct payment (billed-at-home) members. Of total group membership, 74.4% were enrolled under special contracts, with employers contributing a substantial amount toward the cost.

Plan B enrollment (including the "High Option" Federal Employees) stood at 484,747 at the end of the year (it was 415,626 a year ago) and accounted for 63.6% of all enrollment, exclusive of the special Steel program. Membership under the special Steel contracts was 126,966 as of December 31. Continuing the shifting from Plan A to Plan B, which has been typical over the past several years, Plan A membership decreased to 277,859 from the 296,742 of a year ago.

Benefits provided to its members by Blue Shield for physicians' care rose to a record $15,666,826 in 1965, an increase of more than $2 million over the preceding year. The 1965 payments, representing 381,527 separate professional services, brought the amount paid for physicians' care to more than $98,000,000 since the Plan's founding in 1950.

Benefits were received by 241,464 members in 1965, almost 33,000 more than the year before. Included in the 381,527 claims covered during 1965 were 183,947 surgical services, 43,977 medical cases, 10,852 consultations, 13,540 obstetrical benefits, 50,513 anesthesia administrations, 53,101 radiological examinations or treatments, and 25,597 pathologic and other types of services.

Recognizing the value of early detection of disease, Blue Shield, in conjunction with Blue Cross, several years also began making benefits available for diagnostic services at physicians' office or hospital outpatient departments. By the end of 1965, more than 370,000 members had coverage for services of this nature, and more than 43,000 individual examinations were covered during the past year.

Maryland Medical Service continued to act as the fiscal intermediary for the Faculty and the Office of Dependents' Medical Care in 1965. Payments of $301,124 were made to Maryland physicians for their services to the dependents of active duty military personnel under this program, representing 4,201 claims for professional services.

During the year the Plan continued to give increasing attention to improving the effectiveness of its day-to-day working relationships with physicians. At year's end 3,338 physicians were formally participating in Maryland Blue Shield, representing 93% of those physicians who provided services to the Plan's members during the year. In 1965, representatives of the Plan's Physicians Relations Section made more than 2,500 personal visits to physicians' offices, discussing various aspects of Blue Shield operations with physicians and their office assistants.

I appreciate the time and effort given so unstintingly by the members of the Blue Shield Board of Trustees, both lay and physician, and the members of the Reference and Appeals and Medical Relations Committees.

Respectfully submitted,
J. Sheldon Eastland, MD, President,
Maryland Medical Service, Inc.

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

The financial report for 1965 is as follows:

Cash income received from Journal advertising, subscriptions, and other sources ..	$70,142.05
Cost of publishing Journal, including salaries, etc., (exclusive of light, heat, office space)	$82,321.39
Expenses over income	$12,174.34

The figure shown is not a true deficit, however, as the cost of publishing the transactions of the House of Delegates and the Membership Directory are charged to the Journal. In addition, the Journal office turned over to the library nearly $1,000 worth of books sent for review.

Most of the costs of Journal publication are met by advertising revenue. Several years ago the volume of advertising dropped sharply, then began to pick up gradually. Toward the end of 1965 and early in 1966 the advertising picture became much more encouraging. A number of new pharmaceutical firms have begun advertising in our Journal, and many former advertisers have resumed advertising. Four-color advertising has been introduced in our Journal this year.

Over the past few years a tremendous backlog of manuscripts has accumulated, and many authors have been displeased with the long delay between submission of a manuscript and its publication. The delay has been as much as two years. We try to maintain a ratio of approximately 50% editorial matter and 50% advertising. With the recent increase in the number of advertising pages, we are slowly shortening the time lag; but it is still longer than ideal.

Respectfully submitted,
George H. Yeager, M.D., Editor
Doris E. Fletcher, Managing Editor
Editorial Board
Henry P. Laughlin, M.D.
Louis R. Schoolman, M.D.
E. T. Lisansky, M.D.
Edward C. H. Schmidt, M. D.
Houston S. Everett, M.D.
Leon W. Berube, M.D.

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

During the year the Mediation Committee heard many grievances and acted as adjudicator in cases involving unethical acts on the part of physicians, particularly those that were brought to the attention of the Committee. These were in addition to cases handled by component societies, a summary of which is part of this report.

Cases involving court convictions are not acted upon until the Board of Medical Examiners has heard the case and determined its course of action. The Mediation Committee is then guided by the Board's decision.

Most of the cases brought before the committee are not serious enough to warrant court trial and possible conviction. They involve unethical matters which are sometimes hard to define. The committee often finds its hands are tied because the only disciplinary actions it can take are to censure, reprimand, place on probation, or expel from the Society. On the recommendation of the Policy and Planning Committee, a special committee is now studying this matter and, hopefully, can suggest some more adequate disciplinary procedures to be invested in both the Society and the Board of Medical Examiners.

During the year, the Mediation Committee:

1. Found that the program as presented by the Baltimore Regional Joint Board, Amalgamated Clothing Workers of America, Health and Welfare Fund, was not unethical. The decision to participate would rest with the individual physician.
2. Found that some physicians were engaging in unethical conduct by acting as "fronts" or "heads" of lay laboratory operations and not actually supervising or performing any work done by such groups.
3. Discussed with some physicians their alleged falsification and/or illegal submission of Blue Shield claim forms.
4. Reaffirmed the policy that physicians could not submit claims to Blue Shield for work not "personally and actually" rendered by them.
5. Directed a physician to cease engaging in fee-splitting, to which he pleaded guilty.
6. Censured a physician for accepting fees on a contingency basis and for perjuring himself in court.
7. Rendered a decision that it would be unethical for a physician to incorporate any portion of his medical practice as separate and distinct from his professional services.
8. Voted to bring to the attention of the District Medical Society the fact that a physician member of that group was permitting his name to be used in solicitation for laboratory work by a firm operating from Virginia.
9. Did a survey of all lay laboratories in the state to ascertain what role physicians played in operation of such laboratories. It was learned that five of these associations were ethical, five were unethical and the physicians were advised to cease their activity with such operations.
10. Surveyed the few physicians that owned pharmacies in violation of the recently enacted law prohibiting such physician ownership and ascertained that these were legal in view of the grandfather clause in the law.

Mediation Cases Handled During Calendar Year 1965

	Mediation Cases 1965 Total	Cases for Complainant	Cases for Defendant	Cases Pending at 12/31/65	Cases Settled Mutually	No Action	Cases referred to Others BCMS	Referred to Board Medical Examiners	License Revoked	Reprimanded
Allegany County	2				2					
Anne Arundel County	3	1	2	0						
Baltimore City	53	3	19	7	12					
Baltimore County	8	0	6	2						
Calvert County	1	1	0	0						
Caroline County	0	0	0	0						
Carroll County	0	0	0	0						
Cecil County	0			0						
Charles County	0	0	0	0						
Dorchester County	0	0	0	0						
Frederick County	1	1	0	0						
Garrett County	0	0	0	0						
Harford County	1	0	1	0						
Howard County	0	0	0	0						
Kent County	0	0	0	0						
Montgomery County	29	4	22	1						
Prince George's County	19	0	15	4						
Queen Anne's County	0	0	0	0						
St. Mary's County	0	0	0	0						
Somerset County	0	0	0	0						
Talbot County	0	0	0	0						
Washington County	2		1	1						
Wicomico County	1	0	0	1						
Worcester County	0	0	0	0						
CASES HANDLED ON STATE LEVEL	25	3	2		1	10		1	1	7

11. Found that Executive Health Examiners, a service available to Maryland residents, is operating in an acceptable and ethical manner.
12. Was unable to arrive at a conclusion with respect to a charge levied against a physician for alleged assault.
13. Requested appearance of several physicians before the committee, whose cases are still pending at the time of this report.

In addition, the committee was called upon to give opinions with respect to ethical and unethical conduct, to provide members and the public with information on professional matters, and other countless services which bordered on and in the area of ethics.

Respectfully submitted,
Wolcott L. Etienne, MD, chairman
M. McKendree Boyer, MD
Conrad L. Inman, Jr., DDS
John T. Chissell, MD
John M. Dennis, MD
J. Sheldon Eastland, MD
Whitmer B. Firor, MD
Russell S. Fisher, MD
Robert B. Goldstein, MD

Lewis P. Gundry, MD
Howard F. Kinnamon, MD
Louis J. Kolodner, MD
Charles F. O'Donnell, MD

MEDICAL ADVISORY COMMITTEE OF THE RED CROSS BLOOD BANK PROGRAM

Mr. President and Members of the House of Delegates:

The Baltimore Regional Blood Program of the American Red Cross operates as one of 56 blood centers throughout the country under the United States License No. 190 of the National Institutes of Health. It is a national voluntary blood donor service which produces one half of the blood used in the United States. The Baltimore program was established in December, 1958, to supplement the collections of the 32 hospital blood banks operating in the Baltimore area. The Red Cross now provides more than 40% of the whole blood used by these hospitals. In addition, the program is rapidly approaching a total supply of certain important blood derivatives.

The Baltimore Regional Chapter Program is and has been the largest single program in the Baltimore area and is the community's most significant voluntary donor program. It contributes more than any agency or group of agencies toward an adequate community supply of blood. There has been a gradual increase each year; last year the Red Cross collected and distributed 1,153 more pints than the previous year.

More than 800,000 individuals are protected by the Baltimore Regional Program, and this number continues to grow. Both group and individual plans of coverage are offered, making it possible for anyone in the community to participate and receive protection. The Red Cross has concentrated its efforts on the group donor coverage with only limited emphasis on the individual coverage. At the present time the total blood needs of the Baltimore area are estimated at approximately 70 thousand units per year.

The Baltimore program was originally established to supplement the hospital blood banks' supply by *replacing* the blood used for Red Cross eligibles. However, with the introduction of the revolving credit system, sufficient flexibility has been developed so that the Red Cross now distributes blood *in advance of credits,* which is used by the hospitals as needed for any patient. Accordingly, when the Red Cross advances blood to a hospital, it is considered the property of that hospital to be used as needed with the understanding that the hospital take steps to balance the credits used by Red Cross eligibles with the total amount advanced to the hospital.

The Red Cross does not transfuse any blood. It is the aim of the Red Cross, in partnership with the hospital blood banks, to obtain the total amount of blood needed.

The Red Cross also assists hospitals in supplying blood, as available, for *community needs,* including lifesaving emergencies, blood for leukemia and hemophilia patients, and blood for indigents.

All Red Cross blood which is not distributed for transfusion is processed into important derivatives. From December 1, 1958, to December 1, 1965, the 32 participating hospitals received the following:

163,801—units refrigerated whole blood
876—units serum albumin (5%)
3,192—units fresh frozen plasma
795—20 cc units serum albumin
3,410—100 cc units serum albumin
2,573—units gamma globulin
299—units fibrinogen
1,340—units packed red cells
33,076—units gamma globulin were also distributed through the Maryland State Department of Health.

Of the 163,801 units of refrigerated whole blood, 17,379 units were donated to the hospitals to assist those *blood indigents* who could not replace their own blood or were not able to shoulder the financial burden. From the PULSE refrigerator an additional 4,329 units were rushed to the hospitals to help save the lives of 836 patients who needed blood because of an unexpected bleeding emergency.

The original agreement provided for the later development of a Lifesaving Emergency Blood Donor Corps, which would concentrate on enrolling persons of rare types and groups to further assist the hospital blood banks in meeting the general community needs. At a meeting of the Medical Advisory Steering Committee, November 13, 1963, it was considered highly desirable that the Red Cross should take steps to further expand its program to include the emergency donor corps. By so doing, the Red Cross established a separate blood inventory which is reserved for cases certified by the attending physician as being lifesaving emergencies. To make this program successful, the close cooperation of pathologists, blood technicians, and hospital administrators is essential. An effective control was established. The hospital technician is required to secure special authorization from the attending physician, which he submits in writing (within 72 hours) for review by the selected members of the Medical Advisory Committee. Replacements to the pool are made from special evening donations from members of PULSE (Public Unit for Life Saving Emergencies).

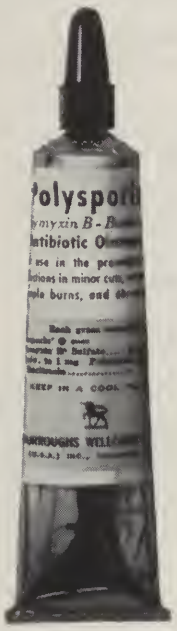
To establish the PULSE donor corps, the Red Cross Recruitment Committee and staff visited the existing blood assurance groups to enlist the support of management and the cooperation of their groups to obtain individual pledges to give blood on call. The Red Cross also invited the general public to join the emergency corps. The active support of the Baltimore Metropolitan Coordinating Blood Council, the Association of Commerce, the AFL-CIO Labor Council, and other appropriate organizations was sought. The PULSE donor corps was properly publicized to stimulate group and individual participation. All donors who are not already covered receive assurance of blood replacement for themselves and their families. The emphasis is placed on community service.

A special group of Red Cross volunteers was organized to assist in scheduling the appointments for the evening PULSE donations. All bloods collected are drawn by certified registered nurses under the supervision of a licensed physician, in accordance with the medical standards of the National Institutes of Health.

The PULSE program requires the continuing cooperation and support extended by civic leaders, the medical and hospital authorities, and the donors who are concerned with the blood needs of our community.

Respectfully submitted,
Everett S. Diggs, MD
C. Thomas Flotte, MD
Carroll L. Spurling, MD
Gerald A. Galvin, MD

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MEDICAL EMERGENCY DISASTER SERVICE COMMITTEE

Mr. President and Members of the House of Delegates:

The MEDS Committee sponsored a resolution urging federal legislation to provide a definition of civil defense to include natural as well as war disasters. This resolution was approved by the House of Delegates in September, 1965.

Several members of the committee attended a meeting of OCD regions 1 and 2, sponsored by Committee on Disaster Medical Care of the AMA Council on National Security, held in Washington, D. C., in August.

Two recommendations were made by the committee to the Executive Committee: 1) that hospitals be urged to combine their Emergency Room Committee and Medical Disaster Committee to make them more active parts of hospital staffs; 2) that hospitals be urged to enforce requirements for two disaster drills per year. These suggestions were carried out in a letter from the Faculty to all general hospitals.

Two bills backed by this committee, which would have extended licensure privilege to out-of-state doctors, dentists, veterinarians, etc. in time of emergency, failed to pass the General Assembly.

The MEDS Committee chairman attended the Conference on Medical Care in Chicago, which was entirely directed toward *natural* disasters.

This committee plans to request an exhibit at the 1967 Annual Meeting, and plans will be made soon for its preparation.

The State Department of Health has implemented a program of Medical Self-Help Training in schools throughout the state, with the support of the Faculty's Subcommittee on Medical Self-Help.

Respectfully submitted,
Charles J. Savarese, Jr., MD, chairman
Frank E. Brumback, MD
Raymond M. Cunningham, MD
E. Roderick Shipley, MD
R. Lane Wroth, MD
Kirk Moore, MD
William J. Peeples, MD
Robert J. Wilder, MD

SUBCOMMITTEE ON PHYSICIAN ASSIGNMENTS: Raymond M. Cunningham, M.D., chairman, E. Roderick Shipley, M.D.

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

A new chairman of this committee was appointed from the ranks of the attorney members. Three subcommittees were appointed.

A symposium, "X-rays in the Courtroom—Fact or Fiction," was prepared by the Symposia Subcommittee and held in December. Another is to be presented at the 1966 Annual Meeting on "Alcoholism and the Law."

Most of the work was accomplished through the Subcommittee on Interprofessional Relations. Several meetings were held to discuss individual requests for assistance from both attorneys and physicians because of a lack of understanding of the Medicolegal Code of Cooperation. Each case was acted upon individually. Certain points of the Code will be clarified in the hope of achieving greater cooperation between the professions.

The question of fees for expert testimony keeps cropping up. The committee is awaiting decisions of the AMA-ABA in this connection so that local problems may be settled.

An Ad Hoc Committee on Traffic Safety was created to consider problems of enforcement of current traffic laws and study of proposed legislation. This committee has not yet met.

Respectfully submitted,
Howard F. Kinnamon, MD, chairman
Conrad Acton, MD
James G. Arnold, Jr., MD
E. W. Ditto, Jr., MD
Russell S. Fisher, MD
Robert W. Johnson, III, MD
J. Elliot Levi, MD
F. Ford Loker, MD
James A. Meath, MD
Belden R. Reap, MD, LLB
Edwin Ruzicka, MD
William G. Speed, III, MD

SUBCOMMITTEE ON SYMPOSIA MANAGEMENT: James G. Arnold, Jr., M.D., J. Elliot Levi, M.D., James A. Meath, M.D., Edwin Ruzicka, M.D.
SUBCOMMITTEE ON INTERPROFESSIONAL RELATIONS: Russell S. Fisher, M.D., Robert W. Johnson, III, M.D., Belden R. Reap, M.D., William G. Speed, III, M.D.
SUBCOMMITTEE ON COURT PROCEDURES: Conrad Acton, M.D., E. W. Ditto, Jr., M.D., F. Ford Loker, M.D.

MEMBERSHIP COMMITTEE

Mr. President and Members of the House of Delegates:

A survey meeting was held by this committee in which present membership and ways of increasing membership were discussed. As a result, a letter was sent to all other state medical societies requesting any solutions they might have found for attracting new members. No outstanding or particularly applicable suggestions were made. In the future, attempts will be made to contact new physicians intending to practice in Maryland.

Eighty new members were admitted to membership in 1965, bringing active membership up to 2,932.

Respectfully submitted,
Nathan E. Needle, MD, chairman
Samuel Borssuck, MD
Edward Davens, MD
Robert A. Gaertner, MD
William G. Helfrich, MD
Frank L. Iber, MD
Frank T. Kasik, Jr., MD
Wallace H. Sadowsky, MD
Emmanuel Schimunek, MD
Moses S. Shiling, MD
Raymond M. Yow, MD

NOMINATING COMMITTEE

Mr. President and Members of the House of Delegates:

(Those elected will assume office at conclusion of the Annual Meeting 1967, unless otherwise indicated.)

President-elect
Richard D. Bauer, Adelphi — President-elect 1966-67; President 1967-68

First Vice-President
HOUSTON S. EVERETT, Baltimore

Second Vice-President
J. HOWARD BEARD, Annapolis

Third Vice-President
FRANCIS J. TOWNSEND, Ocean City

Secretary
WILLIAM A. PILLSBURY, Timonium

Treasurer
KARL F. MECH, Baltimore

Councilors
WILLIAM CARL EBELING, Baltimore, Central District (1970)
J. ARTHUR WEINBERG, Baltimore, Central District (1970)
JOHN F. SCHAEFER, Baltimore, Central District (1970)
JOHN COLLINS HARVEY, Baltimore, Central District (1970)
WILLIAM G. SPEED, III, Baltimore, Central District (1970)
ELDRIDGE H. WOLFF, Cambridge, Eastern District (1970)
WILLIAM B. HAGAN, Riverdale, South Central District (1969) (to assume office 1966)
HENRY P. LAUGHLIN, Bethesda, South Central District (1970)

Delegate to American Medical Association
RUSSELL S. FISHER, Baltimore
(Jan. 1, 1967-Dec. 31, 1969)

Alternate Delegate to American Medical Association
M. MCKENDREE BOYER, Damascus
(Jan. 1, 1967-Dec. 31, 1969)

Committee on Program and Arrangements
ARLIE R. MANSBERGER, Jr., Baltimore (1971)

Library and History Committee
KATHARINE A. CHAPMAN, Kensington (1972)

Finney Fund Committee
RICHARD G. COBLENTZ, Baltimore (1972)

Board of Medical Examiners
ELMER G. LINHARDT, Eastport (June 1966-June 1970)
WILLIAM L. STEWART, Westminster (June 1966-June 1970)

Respectfully submitted,
ALBERT E. GOLDSTEIN*, chairman, Baltimore
J. SHELDON EASTLAND, vice-chairman, at large, Baltimore
ALBERT L. ANDERSON, Southern District, Annapolis
HOUSTON S. EVERETT, Central District, Baltimore
WILLIAM R. GRECO, South Central District, Riverdale
JOHN H. HORNBAKER, Western District, Hagerstown
NORMAN E. SARTORIUS, JR., Eastern District, Pocomoke

*Deceased

OCCUPATIONAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

The Occupational Health Committee met with Messrs. Gibbs and Donnelly, of the Baltimore Area Council on Alcoholism, and John H. Hirschfeld, MD, chairman of the Faculty's Subcommittee on Alcoholism, to discuss alcoholism in industry and ways of recognizing and dealing with it.

In October, 1965, the chairman attended the Congress on Occupational Health in Indianapolis.

Informational material on venereal disease was forwarded to each member of the committee for use in dissemination of this vital information.

Several minor points, such as cooperation with attorneys in supplying patients' reports, on proper request, were discussed and disposed of. Attention will be given in future meetings to problems and programs of industrial nurses.

Respectfully submitted,
JOHN R. DAVIS, MD, chairman
WILLIAM F. COX, *III*, MD
WALTER E. FLEISCHER, MD
HERMAN J. HALPERIN, MD
HARRY L. KNIPP, MD
PATRICK C. PHELAN, JR., MD
DONALD J. ROOP, MD
L. W. SAUNDERS, MD
S. JACK SUGAR, MD
HENRY L. WOLLENWEBER, MD

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

This busy committee has studied, approved, or disapproved many projects and recommendations during the past year. Most of its work is carried out by dedicated subcommittees, with the parent committee meeting quarterly to coordinate activities and pass on recommendations.

Among the achievements of this committee during the past year are: 1) a Salmonellosis Seminar, held in conjunction with the State Department of Health and the USPHS Communicable Disease Center, 2) inauguration of the Medical Education's Dedicated Instructional Channel (MEDIC) for postgraduate education, 3) an unusually successful diabetes detection campaign, 4) an effective tetanus immunization program for industry and the general public, 5) completion and circulation of a retirement booklet, 6) a special issue of the *Maryland State Medical Journal* on "The Mores of Medical Practice," 7) cosponsorship with the Medicolegal Committee of a symposium on "Alcoholism and the Law," to be presented at the Annual Meeting, 8) the writing of a bill to enlarge and amend the present Battered Child law, 9) an active campaign to encourage the enactment of the Implied Consent law.

The Salmonellosis Seminar, held at the Faculty building on October 8, was a well-organized and stimulating conference which attracted many people throughout the state. Its purpose was to alert laboratory personnel and physicians to the recognition and prophylaxis of this common disease.

The March, 1966, issue of the *Maryland State Medical Journal* comprised articles written by members of this committee on the less pleasant aspects of medical prac-

tice, such as drug addiction, alcoholism, traffic safety, and malicious treatment of children. These distasteful areas of human behavior are too often ignored by the practicing physician, although he comes in constant contact with them during his daily practice. This issue of the *Journal* appeals to physicians to understand and treat these problems of medical practice.

Aging—The chief endeavor of this subcommittee has been the printing and distribution of an informative booklet for people contemplating retirement. It describes how they can enjoy fully their new-found freedom. This has been well received by both physicians and the general public, and many additional copies have been requested. Copies are still available from the Faculty office.

Alcoholism—This group has persisted in its work for the advancement of treatment of alcoholism. Through the personal efforts of some members of the subcommittee, several programs have been presented to physicians depicting the treatment of the alcoholic patient. The members of this subcommittee have given unstintingly of their time and have traveled at their own expense to present these programs. A study of the number of psychiatrists in Maryland treating alcoholics, conducted with the cooperation of the Committee on Emotional Health, has provided statistical data. At the request of the Subcommittee, the Council endorsed the Eastern Health District Alcoholism Clinic for an indeterminate period of time. Other activities include the preparation of a symposium on "Alcoholism and the Law" in cooperation with the Symposia Subcommittee of the Medicolegal Committee, to be presented at the Annual Meeting. An exhibit on the treatment of alcoholism will also be displayed during the meeting.

Most recently, the Council of the Faculty and the Executive Board of the Baltimore City Medical Society have approved a recommendation of this subcommittee that a detoxification center be established at the Baltimore City Hospitals. The members of the subcommittee are cooperating with the Mayor's Task Force on Alcoholism to have this much needed facility become a reality.

Plans are also being formulated to present a program on alcoholism over the MEDIC network in the fall.

Through the determined efforts of this group, many advances have been made during the past year and inroads established, which will enable further progress in the aspirations of this subcommittee.

Child Welfare—One of the aims of this subcommittee has been to extend the present legislation pertaining to the battered child to include a central reporting agency and broadening the mandatory reporting requirement to include other professional persons beside physicians. An ad hoc committee was formed to coordinate action with other interested groups, such as the courts, the Criminal Justice Commission, Welfare Department, nurses, and educators. A bill was drafted and presented in the state legislature. Further comment on this legislation may be found in the Legislative Committee report.

An exhibit on the Battered Child Syndrome and one on the Day Care Centers for the Mentally Retarded will be displayed during the Annual Meeting this year through the sponsorship of this subcommittee.

The Council's approval of a statement encouraging the schools in Maryland to engage in a program of tuberculin testing, issued by the Maryland Thoracic Society, represents another success of this subcommittee. We hope this will be implemented in Maryland schools soon.

Continuing Medical Education Program (MEDIC)—After the House of Delegates allocated money from the Educational Fund in September, this project began to take form. It began with presentation of two programs each month to 16 locations and has grown to presentation of from 17 to 22 programs each month to 24 locations. The programs are consistently of the highest quality and are presented mainly by the University of Maryland School of Medicine, Frederick Memorial Hospital, and the Johns Hopkins University School of Medicine. Pediatric and medical grand rounds are also produced weekly from the Johns Hopkins Hospital, and medical grand rounds from the University Hospital will be in the near future. Other presentations have been made by the Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department, the Maryland Pediatric Society, and the Anne Arundel General Hospital.

A series of lectures on the care of the newborn is being presented for nurses, and the Maryland Public Health Association is producing a monthly program for the education of its members.

As interest in the lectures grows and more physicians become aware of their availability, more hospitals are asking to join the network.

This project has proved to be one of the most meritorious activities engaged in by the Faculty, as substantiated by the increasing attendance at the lectures and the many favorable comments.

The Committee on Postgraduate Education, Preventive Medicine, and Public Health recommends that the House of Delegates appropriate from the Educational Fund an additional amount up to $10,000 to be used through December 31, 1966, by the Continuing Medical Education Program Subcommittee to continue and expand the MEDIC network.

Chronic Respiratory Diseases—This subcommittee replaced the former Subcommittee on Tuberculosis. The first area studied was a recommendation that beds, which supposedly are available in the tuberculosis hospitals, be used for persons suffering from chronic respiratory diseases. After thorough consideration, the subcommittee agreed that these beds are not available and that it would be better to have these patients cared for in a more accessible locale. A suitable location for a treatment center is now being sought.

This group is also concerned with the mounting problem of air pollution. It hopes to recommend some concrete corrective steps to combat this menace in the near future.

Diabetes—A three-day diabetes testing program was held again this year at the Fifth Regiment Armory for residents of the Baltimore City area. A new type of retesting program for people with a positive test result was conducted with the cooperation of the Baltimore City Health Department and the State Department of Health. This has proved most advantageous. The success of this follow-up program will attract attention throughout the nation, as this was the first area to employ this form of examination.

A two-day diabetes detection center was held in the Salisbury area, and a one-day program was conducted in Hagerstown. The Baltimore County Diabetes Committee administered a Dreypak campaign with the cooperation of pharmacies in the area.

Many previously unknown diabetics were discovered

during these detection drives, and useful statistical data were accumulated.

Maternal Welfare—Monthly publication in the *Maryland State Medical Journal* of cases of maternal deaths which may possibly have been prevented has been one of the activities of this subcommittee. Cases are reviewed regularly and the most instructive ones are printed. We hope that the Faculty attorney will make a new ruling to enable earlier publication of cases. At present cases are held for three years before publication, and this detracts from the educational value.

Plans are being made to enlarge the membership of this subcommittee and the scope of its activities to delve more deeply into maternal welfare, in order to cooperate more fully with a national survey to be conducted by the American College of Obstetricians and Gynecologists in the coming years and to promote improved maternal care in Maryland.

Pelvic Cancer—The study undertaken last year to determine the incidence and treatment results of carcinoma of the cervix in the State of Maryland has progressed under the direction of Dr. James H. Dorsey. It is anticipated that this survey will be completed during the next few months. No further activity of the subcommittee is planned.

Tetanus Immunization—A comprehensive tetanus immunization program has been conducted by this subcommittee for the past two years. Posters and educational pamphlets urging immunization have been distributed to industrial firms, pharmacies, and physicians throughout the state. With the completion of this worthwhile public service, the subcommittee requested its discharge. We are indebted to this group for implementing such an outstanding program for the education of both physicians and the general public.

Traffic Safety—Facing apathy among the general public, the legislators, and the physicians, this subcommittee has tried many ways of attracting attention to the much neglected and infinitely complex task of promoting traffic safety. The members of the subcommittee have engaged in a personal campaign to encourage the legislators to enact the Implied Consent law, which has been proposed to the State Legislature for the past several years. Further information on this bill may be found in the report of the Legislative Committee.

An ad hoc committee has been formed to plan a seminar on traffic safety in cooperation with the Maryland Chapter of the American College of Surgeons. We hope to hold the seminar this fall in order to generate enough public concern to force the legislature to enact much needed highway safety laws and, through this, to reduce the mounting carnage on the roads.

The chairmen of the subcommittees are to be congratulated for their alertness and industry in performing their assigned duties, which have made this a most productive and successful year for the Committee on Postgraduate Education, Preventive Medicine, and Public Health.

Respectfully submitted,
WILLIAM L. STEWART, MD, chairman
RUTH WORKMAN BALDWIN, MD
ROBERT E. FARBER, MD
NORMAN R. FREEMAN, JR., MD
KARL M. GREEN, MD
FREDERICK J. HELDRICH, JR., MD
JOHN H. HIRSCHFELD, MD
MILTON B. KRESS, MD
WILLIAM P. HORTON, MD
C. RODNEY LAYTON, MD
ROBERT E. MARTIN, MD
WILLIAM J. PEEPLES, MD
ABRAHAM A. SILVER, MD
JOHN WHITRIDGE, JR., MD
JOSEPH B. WORKMAN, MD

SUBCOMMITTEE ON AGING: C. Rodney Layton, M.D., chairman, Archie R. Cohen, M.D., W. Grafton Hersperger, M.D., Louis Krause, M.D., Seruch T. Kimble, M.D., Page C. Jett, M.D., Herman Seidel, M.D., Hugh W. Ward, M.D.

SUBCOMMITTEE ON ALCOHOLISM: John H. Hirschfeld, M.D., chairman, Conrad Acton, M.D., Lewis P. Gundry, M.D., Irene L. Hitchman, M.D., Frank L. Iber, M.D., Isadore Kaplan, M.D., Harry F. Klinefelter, Jr., M.D., Kenneth Krulevitz, M.D., Abraham Schneidmuhl, M.D., Jorge Lopez-Sosa, M.D., Maxwell N. Weisman, M.D., R. Lane Wroth, M.D.

CHILD WELFARE SUBCOMMITTEE: Karl F. Green, M.D., chairman, Raymond L. Clemmens, M.D., Murray M. Kappelman, M.D., Lawrence C. Pakula, M.D., William C. Stifler, Jr., M.D., Robert E. Yim, M.D.

CONTINUING MEDICAL EDUCATION PROGRAM SUBCOMMITTEE: Frederick J. Heldrich, Jr., M.D., chairman, Samuel P. Asper, M.D., Julius Chepko, M.D., Robert J. Furie, M.D., Samuel Gaby, M.D., David J. Gilmore, M.D., H. Logan Holtgrewe, M.D., Arthur T. Keefe, Jr., M.D., Ephraim T. Lisansky, M.D., Albert P. Marsh, M.D., William C. Mulford, M.D., Thaddeus Prout, M.D., George Simons, M.D., John Craig Stauffer, M.D., R. Lane Wroth, M.D., George J. Weems, M.D., John D. Yun, M.D.

SUBCOMMITTEE ON CHRONIC RESPIRATORY DISEASES: Milton B. Kress, M.D., chairman, Warde B. Allan, M.D., Otto C. Brantigan, M.D., Robert J. Farber, M.D., A. Murray Fisher, M.D., John H. Hirschfeld, M.D., Meyer W. Jacobson, M.D., Elliott Michelson, M.D., John E. Miller, M.D., William K. C. Morgan, M.D., William J. Peeples, M.D.

SUBCOMMITTEE ON DIABETES: Abraham A. Silver, M.D., chairman, Neville A. Baron, M.D., DeWitt E. DeLawter, M.D., Robert E. Ensor, M.D., Vincent Fiocco, M.D., Kay K. Edwards, M.D., W. Grafton Hersperger, M.D., Henry J. Houska, M.D., Seth H. Hurdle, M.D., Charles E. Shaw, M.D., Samuel S. N. Sugar, M.D., Sidney J. Venable, M.D.

MATERNAL WELFARE SUBCOMMITTEE: John Whitridge, Jr., M.D., chairman, J. Morris Reese, M.D., George H. Davis, M.D.

SUBCOMMITTEE FOR THE STUDY OF PELVIC CANCER: Howard W. Jones, Jr., M.D., chairman.

TETANUS IMMUNIZATION SUBCOMMITTEE: Robert E. Martin, M.D., chairman, William A. Anderson, M.D., Raymond M. Atkins, M.D., George T. Gilmore, M.D., Leroy W. Saunders, M.D.

TRAFFIC SAFETY SUBCOMMITTEE: Ruth Workman Baldwin, M.D., chairman, Timothy D. Baker M.D., Rudiger Breitenecker, M.D., George O. Eaton, M.D., D. C. W. Finney, M.D., Wm. H. M. Finney, M.D., Irene L. Hitchman, M.D., William P. Horton, M.D., Howard F. Kinnamon, M.D., Paul H. Royse, M.D., Robert J. Wilder, M.D.

AD HOC COMMITTEE ON BATTERED CHILD LEGISLATION: Murray M. Kappelman, M.D., chairman, Lawrence C. Pakula, M.D., Robert E. Yim, M.D.

AD HOC COMMITTEE FOR TRAFFIC SAFETY SEMINAR: Rudiger Breitenecker, M.D., chairman, Timothy D. Baker, M.D., Harold P. Biehl, M.D., Kay K. Edwards, M.D., Abraham J. Mirkin, M.D.

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

The 167th Annual Meeting of the Medical and Chirurgical Faculty, in April, 1965, under the chairmanship of Richard T. Shackelford, MD, was a complete success from all aspects. The total registration, was 1,412, of which 889 were physicians. This was the largest number of physicians to register at a Faculty meeting. The other registrants were mainly paramedical persons, including interns, nurses, and medical students, and exhibitors. Both the Round Table Luncheon and the Presidential Dinner were well attended.

Health evaluation tests for physicians were given for the second year. More than 250 persons were tested, about 70 more than in 1964. Many previously unknown abnormalities were found, and these are being followed up by the chairman, W. Bradley King, MD, and the 1964 chairman, Charles S. Petty, MD.

All technical exhibit space was sold, and scientific exhibit space allotted. The exhibitors were well pleased with the interest shown by those attending the meeting.

The Commander Hotel, in Ocean City, was again the headquarters for the 1965 Semiannual Meeting on Friday, September 10. This meeting was planned by the current committee. The registration was 429, one of the highest in the history of the fall meetings. Robert J. Stewart, administrator for the President's Council on Physical Fitness, gave an enlightening and entertaining discussion on "The Doctor's Role in Physical Fitness."

The Woman's Auxiliary held a meeting featuring a representative from the Institute for Biomedical Research, AMAERF. On September 11, there were meetings of the Maryland Chapter of the American College of Surgeons, the Maryland Psychiatric Society, and the Maryland Diabetes Association. All were well attended. A dinner-dance was held in conjunction with the Faculty's meeting. There was a capacity attendance for the dinner, but not many remained for dancing.

The 168th Annual Meeting will be held at the Alcazar in Baltimore, April 27 and 28, and will be continued aboard the SS Argentina to Bermuda from April 29 to May 4. The same number of scientific sessions as in previous years has been scheduled in Baltimore, starting in the morning of April 27 instead of the afternoon. The House of Delegates will convene on Tuesday evening and Friday morning in the Faculty building. Distinguished physicians from throughout the United States have accepted invitations to present lectures. The first Amos R. Koontz Memorial Lecture will be given by two local surgeons representing the University of Maryland School of Medicine and The Johns Hopkins University School of Medicine.

Each day of the Bermuda Cruise Convention will feature lectures by prominent members of the Faculty and grand rounds films. At this writing, more than 80% of the ship accommodations have been reserved by members of the Faculty and their families.

The usual scientific and technical exhibits will be displayed at the Alcazar. Once again, there is a waiting list of prospective exhibitors, both technical and scientific. Health evaluation tests will be available for the third year, under the chairmanship of Edward L. Sherrer, MD. These have proved to be both popular and worthwhile.

Our committee appreciates diligent efforts of the Faculty staff in carrying out the many details contributing to the success of our meetings.

Respectfully submitted,
John Collins Harvey, MD, chairman
James B. Brooks, MD
Thaddeus E. Prout, MD
Joseph D. B. King, MD
Donald B. Lurie, DDS

SUBCOMMITTEE ON EXHIBITS: James B. Brooks, M.D., chairman, Thaddeus E. Prout, M.D., Richard R. Crane, Sheldon Friedman.

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

The committee met in conjunction with the Legislative Committee. The concept of community service by physicians was unanimously endorsed by the joint group, which included members of the dental profession. Aims and purposes of the educational program of the Faculty were also discussed.

Criteria of the Community Service Award were revised for clarification. Selection was made of the winner of the 1966 award.

A full time staff member was assigned to work solely with Woman's Auxiliary officers, and $500 will be used from the Faculty's operating budget for stationary, printing, etc.

A Subcommittee on Quackery was formed, with the intention of holding a public Congress on Quackery. Material is now being obtained, and other organizations, such as the Heart Association, the Cancer Society and the Arthritis Foundation, will be contacted for possible inclusion in the program.

A series of 12 newspaper articles on various health subjects, entitled, "Your Health and Medicine," was published by the *Baltimore American*, with the assistance of several physicians. This series has already won the Albert & Mary Lasker Award for medical journalism and is a contestant for the 1966 Medical Journalism Award of the American Medical Association.

A proposal to link the physicians of Maryland in a communications network for transmittal of medical education programs was introduced. This program, known as MEDIC, has been developed through another Faculty committee and now links 21 hospitals as well as Hospital Council, State Health Department, and the Faculty. Money from the Faculty's educational fund was requested of the House of Delegates and approved in September, 1965.

Guidelines for the expenditure of the educational funds raised by the special assessment were set out by this committee and adopted by Council. This information, together with data on current expenditures and appropriations from this fund, are to be included in a general mailing to members.

A joint communications workshop and conference was held with the cosponsorship of the dental society. Attendance was good and interest ran high as members of the news media and other public representative groups gave their frank opinions of the medical profession. A panel of physicians and dentists reviewed the program and summarized comments and criticisms.

The annual Smith, Kline and French Speech Training Clinic is planned for October, 1966, in Baltimore, this being the earliest date available. Physicians, dentists, and Woman's Auxiliary members will be invited. Participants will be asked to put their training to use in fulfilling speaking engagements for the Faculty.

Groundwork has been laid for the berthing of the hospital ship HOPE in the port of Baltimore sometime within the next year. Contact has been made with port authorities to see that certain conditions are met.

A seminar for medical assistants was held in April, 1966. Subjects of interest to aides, nurses, and medical secretaries were discussed, such as billing procedures, office organization, legal aspects of medicine, and Medicare.

A program of educational meetings with executive secretaries of component societies has been instituted to keep them informed on current matters and to solve any problems that may exist.

The Public Relations Committee has had a busy year. Its members agree that creating and maintaining the favorable image of the physician in the mind of the public is becoming more and more difficult in the light of recent conflicts. It is, however, the consensus that public relations starts with the individual physician in his own office, clinic, laboratory, and operating room. We call on the profession to assist this committee in the work that must be done.

SUPPLEMENTAL REPORT OF THE CHAIRMAN

The Public Relations Committee held a statewide seminar for medical assistants on April 6, 1966, and considered it important enough to include in this report as a supplement. This all-day seminar, held in Osler Hall, was sponsored by the Public Relations Committee for the benefit of physicians' aides, secretaries, nurses, and other office assistants. The program consisted of talks by knowledgeable persons in the field, followed by question and answer periods. Response has been very enthusiastic, and similar workshops are planned on an annual basis, or more often if feasible.

Respectfully submitted,
Manning W. Alden, MD, chairman
John W. Clark, MD
David S. Clayman, MD
Robert B. Goldstein, MD
Calvin Y. Hadidian, MD
Walter E. James, MD
Robert L. Gray, MD
H. Berton McCauley, DDS
E. Roderick Shipley, MD
Mrs. John E. Baybutt
Joseph H. Seipp, Jr., DDS

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on Thursday, March 31, 1966, to discuss the two resolutions introduced for consideration by the House of Delegates on April 29, 1966. The meeting was well attended and the discussion was most interesting.

As has been the custom, your Committee will recommend action to the House. The question, however, will be on the Resolution itself and not upon the Committee report. All decisions were reached in accordance with the Faculty's Bylaws, Article X, Section 23.

RESOLUTION 1A/66

Submitted on: January 26, 1966

Introduced by: Maryland Radiological Society

Subject: Support Separating Professional Fees from Hospital Charges

Whereas, It is now the declared policy of the American College of Radiology that members of the College shall separate their professional fees from hospital charges and present their own bills to all patients expected to pay for services; and

Whereas, The House of Delegates of the American Medical Association on October 3, 1965, stated, "Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians."; and

Whereas, Congress established under the Medicare law, PL 89-97, provisions covering Radiology solely as a medical service, and radiologists are obligated to obey those legislative provisions; and

Whereas, The identification of radiology as a hospital service has led physicians away from training in the specialty of radiology, and has jeopardized the future of radiological practice and thus of all medical care due to professional personnel shortages; and

Whereas, Separate billing for professional services is feasible and desirable for *all* patients served by radiologists in hospital departments, just as it is for surgeons, obstetricians, internists, anesthesiologists, and other practitioners of medicine; now, therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland supports the policy of the American College of Radiology, the American Medical Association, and of Medicare law PL 89-97, of separating professional fees from hospital charges; and

Resolved, That copies of this resolution be sent to the American College of Radiology, the Hospital Council of Maryland, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

This resolution is similar in content and intent to one introduced at the AMA House of Delegates session in Philadelphia in December, 1965. This was adopted unanimously by that House.

The Faculty's Council has also endorsed this principle at its January 27, 1966, meeting.

In view of this, and the Faculty's long-standing position that professional fees be separate from hospital charges, your Reference Committee recommends adoption of this resolution.

RESOLUTION 2A/66

Submitted on: January 27, 1966

Introduced by: Washington County Medical Society

Subject: Requesting Legislation for the Creation and Maintenance of a School of Medical Technology within the University of Maryland

Whereas, The shortage of properly qualified medical technologists remains acute, appears to be worsening and will become more and more acute in response to the increasing demands of coming years, and in view of the fact that theirs is a profession in which the work involved is becoming increasingly complex and important to patient care so that it is felt action must be taken at once to relieve the situation; therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland requests that the Maryland General Assembly appropriate the initial sum of at least fifty thousand dollars for the establishment of a formal School of Medical Technology at the University of Maryland and that sufficient appropriations be made annually thereafter for maintenance of same; and

Resolved, That the University of Maryland be commissioned and designated to establish and operate this school on a scale specifically designed to benefit equitably all geographic areas in the State of Maryland and expressly with the purpose of relieving present and future shortages in medical technologists in all areas of the State of Maryland; and

Resolved, That this School of Medical Technology be established within the University of Maryland in an organizational manner analogous to that of the Schools of Medicine, Dentistry, and Pharmacy; that the standards maintained in this school be satisfactory to the American Medical Association, the American Society of Clinical Pathologists, and the American Society of Medical Technologists, and to their respective Maryland component societies, and that the graduates be awarded the B.S. degree and be eligible by examination for certification and the professional designation M.T. (ASCP).

In recent weeks, considerable newspaper publicity has been published, all dealing with the shortages in these areas. In addition, the 1966 General Assembly adopted several resolutions urging attempts be made to recruit paramedical personnel.

For several years now the Faculty has participated in the Maryland Health Careers Council, a cooperative effort on the part of health and health-related agencies

to cooperate effectively in recruitment of young people into medicine, nursing, and other allied health fields.

The State Department of Health in its 1966 fiscal year budget requested the sum of $50,000 to establish a career recruitment program aimed specifically at the shortages in the health-related fields. This was cut from the budget by the Budget Bureau.

The Governor's Commission to Study the Shortage of General Practitioners in Maryland made a similar recommendation, although emphasis was to be placed on the recruitment of young people who would enter the field of medicine and agree to practice in the more rural areas of the state.

Since the introduction of Resolution 2A/66 and the appearance of several stories in the newspaper emphasizing the shortage of medical technologists, an announcement has been made by Wilson H. Elkins, president of the University of Maryland, that such a course may be instituted at the College Park campus in the fall of 1967. Funds for establishment of such a course would be included in the fiscal 1968 budget, it was stated.

It is evident that a shortage exists in the areas outlined in this resolution. Adoption of the resolution would add strength to the proposal as suggested by Dr. Elkins.

Your Reference Committee, therefore, recommends adoption of Resolution 2A/66.

It is noted that other schools may also be willing and able to establish such schools by coordinating their activity with hospitals, as well as other means. **In view of this, the Reference Committee also recommends that all appropriate universities in Maryland be requested to give this possibility some study and be advised that the counsel and advice of the Faculty and its members are available in this area.**

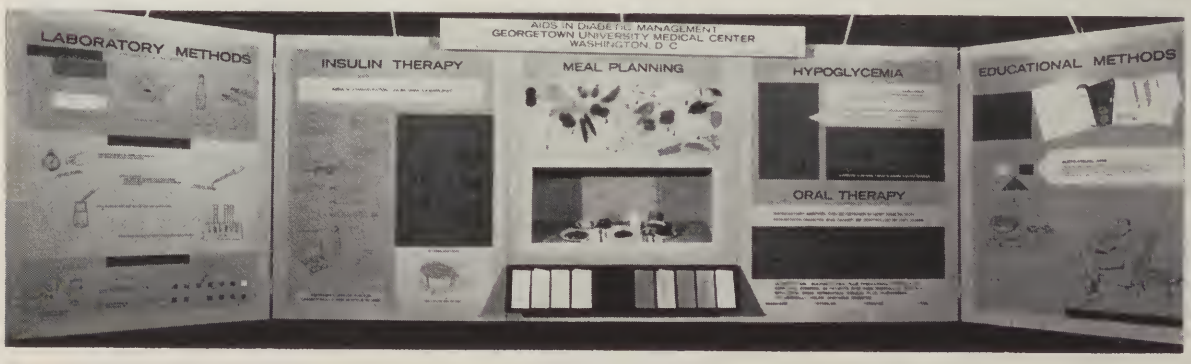
The Reference Committee also has an additional recommendation that the Faculty's Legislative Committee and approved legislative representative at the Annapolis General Assembly sessions be instructed to work closely with the University of Maryland in ensuring that funds for development of this course of training are retained in the University of Maryland budget.

The Reference Committee expresses its appreciation to all who assisted in its deliberations.

Respectfully submitted,
William B. Hagan, MD, chairman
DeWitt E. DeLawter, MD
Everett S. Diggs, MD
William G. Helfrich, MD
Howard F. Kinnamon, MD

An Aesculapius Award, offered by Mead Johnson Laboratories, was presented to De Witt E. De Lawter, MD (left), for his exhibit "Aids in Diabetic Management." During the 1966 Annual Meeting, a committee of the Medical and Chirurgical Faculty selected this exhibit as the one best representing "excellence in concept, originality, and execution of a scientific exhibit." John Collins Harvey, MD, chairman of the Faculty's Committee on Program and Arrangements, made the formal presentation of a plaque, a certificate, and a check for $200.

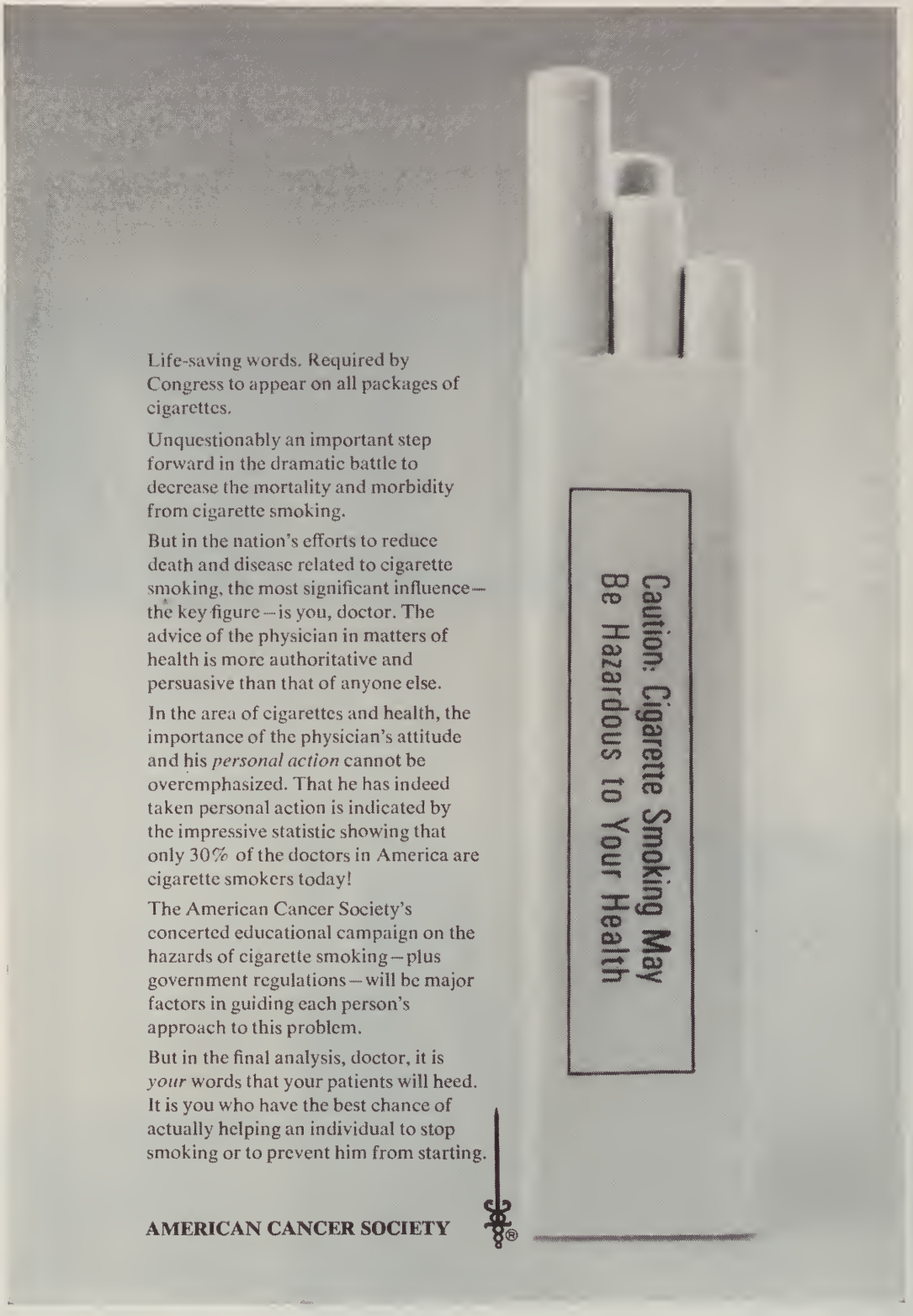
This award will be given again in 1967. All exhibits accepted for showing at the 1967 Annual Meeting of the Medical and Chirurgical Faculty will be eligible for judging. Physicians interested in showing an exhibit at this meeting should apply to the Chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral Street, Baltimore, Md 21201.





While Maryland and Bermuda physicians shared medical information, their wives became acquainted at a tea given by the Maryland Woman's Auxiliary.





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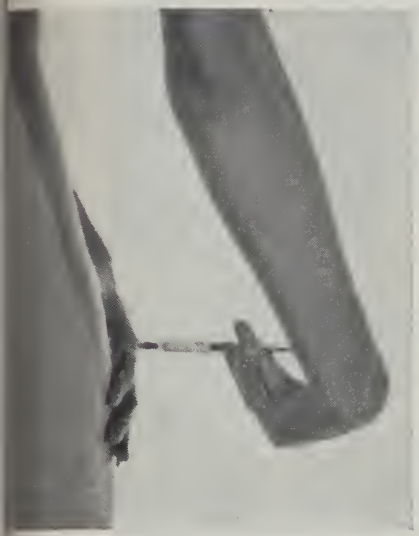
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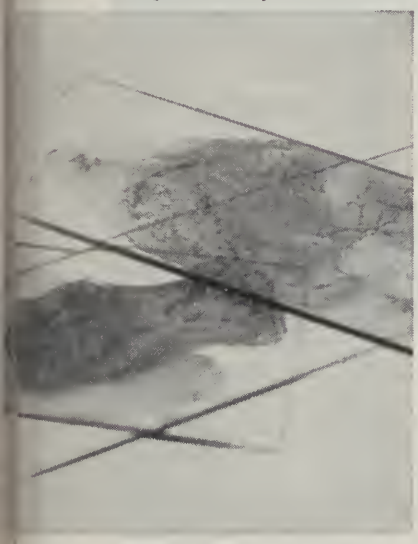
2. nonpregnant women with a history of recent or recurrent monilial vaginitis



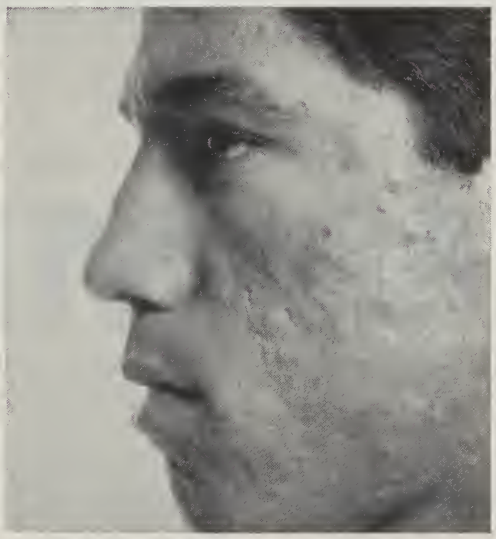
3. elderly or debilitated patients



ıtients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



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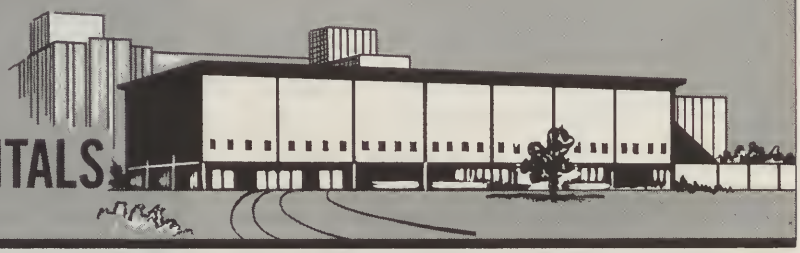
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HISTORY OF THE BALTIMORE CITY HOSPITALS

BY DOUGLAS CARROLL, M.D.



Chapter 7.—The Bayview Asylum: The Influence of a University (1891- 1911)

It requires no prophetic eye, no special foresight, to discover that we are on the very verge of one of the most fearful and wide-spread revolutions in medicine that the world has ever witnessed; another of those astounding changes whose name is already legion, and which, whether for good or evil is destined to convulse the profession, and to exert a most powerful influence upon the practice of the healing art. (Samuel Gross, 1861)

The Revolution in Medical Teaching

In the year 1891, the Trustees of the Baltimore City Almshouse developed a system of student and residency training similar to what was being developed at the Johns Hopkins Hospital. Residents, assistant residents, and medical students were nominated by the medical schools to the Trustees for appointment at the Bayview Asylum. Students were directed to make up individual charts on patients in a methodical manner, to record treatment, and to keep progress notes. The three medical schools in Baltimore at that time—the University of Maryland, the College of Physicians and Surgeons, and the Johns Hopkins University—agreed to have one or more physicians from their respective faculties visit the Almshouse daily. The visiting men were required to be present at all important surgical or obstetrical operations. The residents were responsible to the visiting men; the assistant residents to the residents; and the student to the assistant residents. Four students were appointed by the University of Maryland and four by the College of Physicians and Surgeons to live in the Almshouse and pay the Trustees at the rate of $330 per year.

The influence of the Johns Hopkins Medical School at the Almshouse goes back to 1884, when Dr. William Welch arrived in Baltimore to begin his work as professor of pathology in the new medical school. He needed material with which to teach the students who had gathered around him. He turned to his assistant, Dr. William T. Councilman, a Baltimorean, who had been working at the Almshouse for several years. In following years, Drs. Councilman, Halsted, and Thomas, of the medical school, served as visitors in the insane hospital, reorganized the records, taught, and attracted younger doctors. Medical students were instructed in the insane hospital.

The revolution in medical education brought about at The Johns Hopkins Hospital and Medical School was the elevation of the practice of medicine from the bedside and autopsy table to the laboratory of the university and the research building. There was an advance from description and empiricism to planned experiment, statistical analysis and clinical trial.[1]

Specialization

A new influence was that of specialization. In 1885, the resident in the insane asylum for the first time made a separate report on the insane



Fig 1

William Thomas Councilman (1854-1933) MD, University of Maryland (1878); pathologist Bayview Asylum, 1879; student of von Recklinghausen at Strassburg and Cohnheim at Leipzig 1880-1883; visiting physician to the insane wards at Bayview (1883-1892); Shattuck Professor of pathology at Harvard Medical School, 1892. (Collection of Medical and Chirurgical Faculty of Maryland).



Fig 2

Views of wards in Bayview Asylum 1900.

patients. The only other service was a combined medical and surgical service. This division of the insane department from the general medical responsibility was the forerunner of more intensive specialization.

In 1890, a separate ward was established for patients with pulmonary tuberculosis. This was the first example in the United States of a separate ward for tuberculosis patients in a general hospital.

In 1893, the Trustees noted that many of the patients who entered the Almshouse returned to the community as valuable members thereof after they had received treatment. In 1894, unemployment was again recognized as affecting the infirm and elderly first.

In 1896, the admissions to the hospital were put on a more businesslike basis, a recognition of the fact that the problems of the poor could be handled in a logical and organized manner.

Around the turn of the century, a number of new influences developed at the Almshouse. The state mental hospitals began to take some of the insane patients, but the Almshouse insane hospital remained crowded. In 1897, a city ordinance abrogated the power of police magistrates to issue hospital permits to people appearing before them, thus decreasing the number of vagrants and alcoholics sent to Bayview. In 1898, a careful attempt to isolate all infectious diseases in the hospital was carried out. Improved screening of applicants to the Almshouse was started. These measures resulted in fewer insane, vagrant, and alcoholic people being admitted, making room for sick patients.

In 1904, another attempt was made to limit the power of police magistrates to send "beats and bums" to the Almshouse. It was pointed out that the Almshouse was neither a reformatory nor a penal institution. In 1906, a special plea was made by the Trustees for help in the care of chronic alcoholics and drug addicts. The problem of promiscuity in young girls was mentioned, and it was clear that the Trustees recognized that these were social problems that were not being met.

In 1908, in the report of the Trustees, a number of case histories were presented of patients with tragic social problems, demonstrating that the patients were the victims of circumstances and not responsible for their conditions.

In the same year, a special committee of experts was appointed by Mayor J. Barry Mahool to discuss the problems of the Bayview Asylum. It recommended a 300-bed hospital, more beds for tuberculosis patients, renovation and reconstruction of the Almshouse, and construction of new administrative facilities.

Growth of State and Federal Participation in Welfare Activities

Toward the end of the nineteenth century, the recurrent economic depressions brought acceptance of the view that poverty and unemployment might be the result of economic depression rather than individual fault. In 1908, certain states passed laws on industrial accidents, factory inspection, and regulation of child labor. The United States Children's Bureau was founded in 1912. A Federal Compensation Act, in 1908, covering government employees, led the way to state enactment of Workmen's Compensation laws. Workmen's Compensation laws, the welfare of children, a mother's pension law, and the needs of the blind all had their groundwork laid in many states before the First World War. The First World War and the period afterward resulted in little advance in the social reform movement except for the grants-in-aid for vocational rehabilitation of disabled persons in 1920.[2]

During the first two decades of the twentieth century, psychiatry increased its scope from that of a medical discipline to one including the study of psychological and social factors in mental illness. The development of social psychiatry from psychiatric social work was stimulated by the work of Elmer E. Southard in the second decade of the twentieth century.[3] Adolf Meyer, at the opening of the Phipps Psychiatric Clinic at The Johns Hopkins Hospital, in 1913, called for the broadest approach to psychiatric problems, using all possible disciplines and resources for their investigation. Particularly, he pleaded for psychiatric clinics to study and respond to the social and mental atmosphere of the local community.[4]

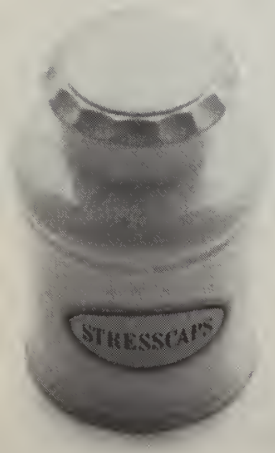
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BALTIMORE CITY

The Executive Board of the Baltimore City Medical Society met on May 10. **Dr. Hogan** discussed the problems of a fee schedule in relation to Blue Shield payments and the inception of the Medicare program. A thorough discussion ensued. It was agreed that a letter would be sent to Mr. Denwood Kelly, offering full cooperation of the Board of Directors of the Baltimore City Medical Society in assisting Blue Shield to prepare for the advent of Medicare.

A suggestion for a summer program was received from **Dr. George Vash.** In line with the decision taken by the Board of Directors at its meeting on April 12, Dr. Vash is to be notified that his activities were unnecessary.

Alfred C. Moore, MD, transferred from active to associate membership.

A sum of $100 is to be given to the Student American Medical Association at the University of Maryland for assistance of members attending the annual meeting.

John Collins Harvey, MD

HARFORD COUNTY

Speakers for the last three meetings of the Harford County Medical Society were **Byron Brogdon, MD,** on Radiologic Diagnosis of the Low-Back Syndrome; **William F. Rienhoff, Jr., MD,** on Carcinoma of the Lung, and **Donald Benson, MD,** on Cardiopulmonary Resuscitation. Subsequently, Heinz R. Linden, MD, chief of

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Anesthesia, Harford Memorial Hospital, has given demonstrations of "Resuscianne."

At the March meeting, announcement was made that the Woman's Auxiliary to the Harford County Medical Society was making a donation to the AMA Education and Research Foundation for the student loan guarantee fund, in honor of the Harford County Medical Society on Doctors' Day March 30, 1966.

James McC. Finney, MD

WICOMICO COUNTY

Medicare rules and regulations were the topic for the May meeting of the Wicomico County Medical Society. Benefits, methods of physician reimbursement, and effect upon routine office business procedure were covered by a series of speakers, including **John Sargeant,** executive secretary of the Medical and Chirurgical Faculty; **Denwood Kelly,** director of the Maryland Blue Shield plan; **John Webb,** also representing Blue Shield; and **Leonard Kilbourne,** of Medical Management Consultants of Delmarva.

After the society meeting, Messrs. Sargeant, Kelly, and Webb remained in Salisbury to conduct a similar briefing program the next morning for office assistants. Approximately 55 physicians' employees attended that session, which was held in the auditorium of the Peninsula General Hospital School of Nursing.

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arks, V., and Dawson, A.: it. M. J. 1:293, 1965.

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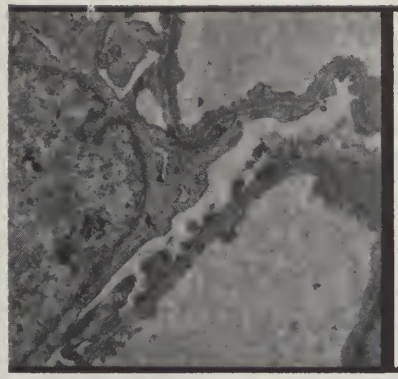
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"Some of us will smart for it"*

RUDIGER BREITENECKER, MD
Chairman, Ad Hoc Committee of the Traffic Safety Subcommittee

In 1965, nearly 50,000 persons were killed in traffic accidents, millions were injured, and untold millions of dollars in property damage were sustained. Maryland contributed her share in this "senseless slaughter" on the streets and highways with 696 traffic fatalities. The public and its political representatives are dulled by this daily mayhem on the road; some seem to considere it a risk of modern life, albeit an annoying one. More and more citizens, however, recognize the need of curtailing these untimely deaths, and a great variety of programs are in existence to enhance these perspectives. The yearly rising toll in traffic fatalities testifies to the poor results that such efforts have met. It is ironic to compare these frustrating efforts with the amount of energy and money spent on the solution of the poliomyelitis scourge, that at its worst killed less than one-tenth of the number killed in vehicular accidents.

What can be done? It seems that one of the major and well recognized causes that is amenable to correction should be attacked first and vigorously. This is the problem of the drinking driver. Year after year, we at the Medical Examiner's office find that half of the dead drivers were "under the influence" of alcohol, that is, their blood alcohol level was above 0.10%. Repeatedly it has been shown conclusively that such a driver is a menace to himself and, worse, to the lives of others as well. Yet the present judicial attitude shows complete unwillingness to adequately punish such offenders, frequently for "lack of evidence."

For many years efforts have been made to have Maryland legislators enact an implied consent law, which would allow temporary suspension of the driver's license for refusing a breath-alcohol test ordered by a law enforcement officer. Under present conditions a driver knows from extensive news coverage that it is fairly easy to beat a drunken driving charge.

Without such legislation, law enforcement and protection of the public against the menacing drinking driver are seriously jeopardized. This becomes evident by the increasing number of refusals to submit to the breath test, which had reached 40% in 1965. In the same year, 95% of the drivers tested had blood levels in excess of 0.10%, which means that their driving ability was seriously impaired.

One wonders about the motives that have prevented passage of this essential bill. The most common criticism is that this type of law is unconstitutional. However, this charge is unfounded, since 16 other states have such a law in effect, and many courts have held such legislation not to violate any constitutional rights. The American Trial Lawyers Association favored such legislation, and the Medical and Chirurgical Faculty has strongly endorsed the efforts of the law enforcement agencies to have such a bill passed; but it has been ignominiously defeated each time.

As physicians, we are concerned with prevention of traumatic as well as pathologic illness.

*Shakespeare: *Much Ado About Nothing,* Act V, Scene 1.

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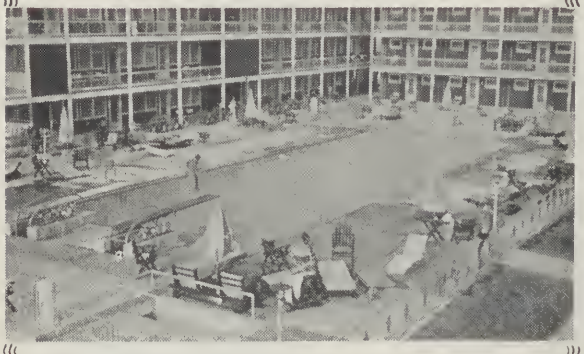
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The Heart Page

Kenneth B. Lewis, MD—*Editor*

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IDIOPATHIC MYOCARDIOPATHY

Part II: Treatment and the Role of Long Term Bed Rest

GUSTAV C. VOIGT, MD
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Heart failure from idiopathic myocardiopathy is a challenging therapeutic problem. While it may respond satisfactorily at first, relapses are frequent and cardiomegaly, gallop rhythm, and chronic cardiac decompensation may persist in spite of ideal management. Low cardiac output, arrhythmias, and pulmonary and systemic emboli compound the situation further. Although the treatment of heart failure and its complications in patients with idiopathic myocardiopathy is basically the same as that for heart failure from other causes, certain aspects of this disease merit special therapeutic consideration.

Diuretics

Salt restriction and the judicious use of diuretics are routine measures in heart failure. Use of mercurials presents no particular problems in patients with idiopathic myocardiopathy. It has been suggested that thiazides not be used because of the danger of producing hypokalemia in patients who may be receiving digitalis and in whom arrhythmias are common.[1] We believe that thiazides can be used safely as long as supplemental potassium is given. Aldosterone antagonists, (spironolactones) may be beneficial in some patients who have edema refractory to other agents, but these drugs may produce hyperkalemia even when administered with thiazides, particularly in the presence of renal insufficiency which often is present in patients with idiopathic myocardiopathy who have extraordinarily low cardiac output and decreased renal blood flow.[2,3] Ethacrynic acid, a new and potent diuretic, is presently limited to investigational use. It should be given cautiously and only when more conventional measures fail to promote diuresis. Patients with edema, low cardiac output, and diminished renal blood flow may not tolerate the acute decrease in blood volume which may accompany the sudden and copious diuresis produced by this agent.[4,5]

Digitalis

It has been suggested that patients with idiopathic myocardiopathy are exceptionally sensitive to digitalis.[1,6] Such observations are diffi-

From the Departments of Medicine, The Johns Hopkins University School of Medicine and The Johns Hopkins Hospital and Baltimore City Hospitals.

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Dr. Voigt receives support from a National Institutes of Health Research Fellowship I-F2-HE-28,655-01.

cult to evaluate since arrhythmias are common in this disease even in the absence of digitalis. Our experience, and that of others, indicates that most of these patients can tolerate digitalis and that it should be used when indicated.[6, 7] Shorter acting preparations, such as digoxin, are safer since the toxic effects are more readily reversed when the drug is stopped. Starting the patient on a maintenance dose rather than on the conventional loading dose may increase the margin of safety yet provide sufficient digitalis to improve myocardial function.

Anti-Arrhythmic Agents

The high incidence of arrhythmias, most commonly premature ventricular contractions and atrial fibrillation, may prompt the use of an anti-arrhythmic agent, such as quinidine or procaine amide. These drugs depress myocardial contractility, and their use in patients with poor myocardial function and low cardiac output must be considered carefully.[8] We would reserve the use of such drugs for potentially life-threatening arrhythmias and not use them to suppress frequent premature ventricular contractions unless they occur in runs or are multifocal and the threat of ventricular tachycardia or fibrillation exists.

Anticoagulants

The role of anticoagulants in patients with heart disease is controversial. If the therapeutic aim is to decrease the likelihood of pulmonary embolism from pelvic and deep leg vein thrombosis induced by shock, heart failure, or prolonged bed rest,* then the use of anticoagulants is probably salutary.[9] There is evidence, however, that they will not prevent mural thrombosis in the heart, a common event in idiopathic myocardiopathy and the source of systemic emboli.[10] Systemic emboli often occur in such patients who are adequately anticoagulated.

Steroids

Reversal of a deteriorating course concomitant with the administration of high doses of adrenocorticosteroids has been reported in patients with *acute* myocarditis. The use of steroids is justifiable and probably indicated in such patients who are not responding to other measures.[11-14] In idiopathic myocardiopathy, however, the response to steroids has been generally disappointing. There is little evidence of any therapeutic benefit, and undesirable side effects and complications of steroid therapy interdict their administration in any routine fashion. In an occasional patient with idiopathic myocardiopathy the addition of steriods seems beneficial, so their trial use in the desperately ill patient may be justified.[6, 12]

Long-Term Bed Rest

Patients with idiopathic myocardiopathy often have persistent cardiac dilatation and are in a state of chronic uncompensated heart failure. Since the dilated heart is inefficient and operates at a tremendous mechanical disadvantage in its function as a pump, prolonged bed rest in a controlled hospital environment has been advocated as a means of reducing blood volume and cardiac size and improving mechanical efficiency. Burch has reported a significant reduction in heart size and improvement in heart failure in patients with idiopathic myocardiopathy after periods of bed rest of 18 months or more.[1] The early results of our experience with a program of long-term bed rest in such patients appear to confirm his studies. In order to properly evaluate these observations, however, and to establish the place of long-term bed rest in the treatment of idiopathic myocardiopathy, we need to know the course of such patients after a period of bed rest. Because long-term bed rest imposes severe social and economic hardship on the patient and his family, it is important to learn whether the improvement brought about by such a program is maintained after he returns to the community and whether his ultimate prognosis is significantly altered.

*Burch reports that long-term bed rest does not seem to increase the incidence of pulmonary embolism in patients with idiopathic myocardiopathy.

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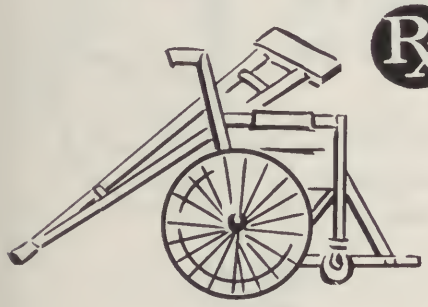
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REHABILITATION SECTION
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DOUGLAS G. CARROLL M.D.
EDITOR

Problems of Diagnosis in Chronic Diseases *Part II*

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Chief of Physical Medicine and Rehabilitation, Baltimore City Hospitals

Hemiplegia

Cerebrovascular occlusion or hemorrhage followed by infarction of the brain with hemiplegia is such a common occurrence in elderly people that the presence of rare curable causes of hemiplegia is apt to be overlooked. It is possible that the recent interest in identifying stenosis of a carotid artery may result in prevention of a small number of cerebral infarctions. Patients with meningiomas, subdural hematomas, meningococcal meningitis, acute syphilitic meningitis, and tuberculous meningitis may present with hemiplegia of rather rapid onset. An early correct diagnosis and appropriate therapy in such patients may result in complete recovery.

A 16-year-old girl was transferred from another hospital, where she had been for two weeks with a hemiplegia and diagnosis of poliomyelitis. She was found at operation to have a subdural empyema and made a partial recovery after one year.

A 52-year-old man was transferred from another hospital, where he had been for a week with a diagnosis of cerebrovascular accident and hemiplegia. He was found to have a brain abscess, which was drained, but he did not regain complete function.

A 75-year-old woman, eight days before admission, was found to be unable to speak and became bedridden. The fundi were inadequately visualized. She responded minimally to commands. There was definite weakness in the left leg. The eyes deviated to the left. There was bilateral hypereflexis, a fixed and dilated left pupil, and a left facial weakness. She suffered several right sided convulsions. The plantar responses were extensor.

A lumbar puncture performed on the day after admission showed an opening pressure of 230mm of saline, three cells, and no increase in protein. The blood serologic test for syphilis was positive. The fasting blood sugar was 392mg% and the glucose tolerance test was abnormally high. Insulin, phenobarbitol, and a 1,500 calorie diet were started. The temperature rose to 103 on the eleventh hospital day, and penicillin and streptomycin were started with the presumptive diagnosis of aspiration pneumonitis. The fever persisted. The leukocyte count rose to 24,500, and she died on the sixteenth hospital day.

Postmortem examination showed a subdural hematoma covering the entire right hemisphere. There was atrophy and laminar necrosis under the hematoma. There were mild changes in the kidneys thought to be compatible with diabetes mellitus. There was syphilitic aortitis and slight enlargement of the heart with mild coronary artery thickening and myocardial fibrosis.

The gradual development of the hemiplegia, the presence of convulsions, the elevated spinal fluid pressure, and the dilated pupil suggested retrospectively that this patient did not have an ordinary cerebrovascular occlusion.

A 74-year-old Negro woman was admitted from a nursing home on July 14, 1961, because of a generalized convulsion. For several years there had been increasing mild disorientation, but the

patient never had experienced a previous convulsion.

Initial examination revealed a blood pressure of 175/110, a regular pulse with a rate of 92 per minute, and respirations at 16 per minute. The patient was somewhat disoriented, but except for evidence of moderate emphysema, the general physical examination was not remarkable. There was slight tenderness on percussion over the left side of the skull; no bruit was noted. Extraocular movements were normal, and there was no papilledema. There was a mild left hemiparesis and a moderate right hemiparesis with bilateral positive Babinski signs. Sensory examination was not entirely satisfactory, but there was no gross loss of position or vibratory sensation. Reflexes where hyperactive everywhere but slightly more in the right upper and lower extremities. There were no cerebellar signs.

On admission, the urine, blood, and electrolytes were normal. An expanding intracranial lesion was suspected. A brain scan with arsenic 74, on August 13, was unremarkable. A lumbar puncture yielded clear fluid with an opening pressure of 120 and a closing pressure of 85. The protein was 51 mg%, the chloride, 118mEq/l. There was no growth on culture. Electroencephalogram showed a diffusely abnormal record with a little more abnormal activity in the left hemisphere than in the right. It was felt that the tracing did not constitute good evidence for a space-occupying lesion. X-rays of the skull revealed advanced hyperostosis frontalis interna. No displacement of the pineal gland was noted.

On September 13, the jaw jerk was noted to be hyperactive and there was increased tone on both sides with greatly increased deep tendon reflexes but no clonus There was a well developed grasp reflex on the right. The patient's disorientation had increased since initial diagnosis.

Over the next few days the patient developed bronchopneumonia, refused to eat, developed severe hypernatremia, went into renal failure, and died on November 2.

A complete postmortem examination revealed pneumonia of the right upper and right lower lobes and the left lower lobe with diffuse emphysema. There was moderate atherosclerosis, nephrosclerosis, and hyperostosis frontalis interna. When the brain was removed from the cranial cavity, a 2x3cm pale pink mass was noted 4cm anterior to the optic nerves in the anterior fossa of the base of the cranium in the midline. This turned out to be a meningioma.

Endocrine and Metabolic

Methods of diagnosis of endocrine and metabolic disease have advanced as rapidly as our ability to treat them, and it is rare indeed for a patient with these diseases to die undiagnosed and untreated. To be sure, irreparable neural damage may occur before a diagnosis of pernicious anemia is made; and patients die of myxedema and Addison's disease, but generally not without a diagnosis.

One patient presented a most confusing clinical picture of anorexia, nausea, vomiting, weakness, dyspnea, tarry stools, electrocardiographic changes, a rising serum urea nitrogen, and lethargy—perfectly classical, in retrospect, of hypercalcemia (17.8 mEq/1) and parathyroid adenoma. Unfortunately, a blood calcium was not obtained until the day of death.

Summary

In the management and rehabilitation of elderly patients with chronic diseases, the physician must be alert to diseases which are treatable or curable. Treatable diseases may be concealed by the presence of another more obvious incurable disease. Treatable diseases most frequently missed are infections (especially tuberculosis), intra-abdominal abscesses, perforations and gangrene, various diseases presenting with a hemiplegia, and, more rarely, endocrinopathies.

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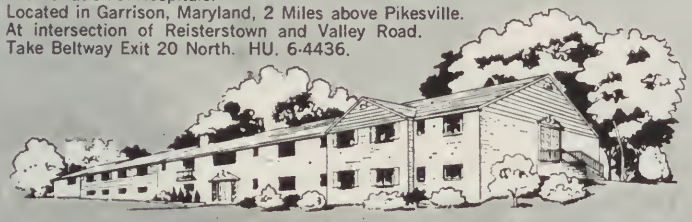
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Hyperplastic Cholecystoses

S. I. MARGULIES, MD
B. G. BROGDON, MD

In 1960, Jutras[1] described a group of nonmalignant noninflammatory gallbladder conditions having related pathologic, physiologic, and radiologic changes. He suggested the term *hyperplastic cholecystoses* to encompass these entities—cholecystoses, since they seem to be related to an inflammatory process only incidentally; hyperplastic, since they appeared as a disordered result of overwork or as a premature manifestation of senescence.

The major entities included in the hyperplastic cholecystoses are cholesterolosis, adenomyomatosis, and neuromatosis. All are, in a sense, degenerative phenomena; frequently they coexist.

Radiographically, these conditions are manifest on contrast studies by filling defects or abnormal configuration of the gallbladder in association with hyperconcentration, hyperexcitability, and hypersecretion.

CHOLESTEROLOSIS is characterized by multiple mucosal collections or excrescences of cholesterol deposits which may be either diffuse and granular or disseminated and multiple (Fig 1). These cholesterol "polyps" are usually less than one centimeter in diameter and are best seen in the contracted gallbladder, either as notches if seen tangentially or as filling defects if seen *en face* (Fig 2). Ordinarily these polyps maintain a relatively fixed position on the gallbladder wall.

Nonlithic filling defects of the gallbladder are differentiated from stones by virtue of their peripheral location and relative lack of mobility. In the differential diagnosis of the various nonlithic filling defects, one must consider cholesterol polyps, true adenomas (papillomas), and inflammatory polyps. Cholesterol polyps are the most common. They are usually multiple and vary from 2-6mm in greatest diameter. Adenomas are rare and are usually solitary, measuring 3-8mm. Inflammatory polyps are even more rare and are associated usually with severe cholecystitis, which virtually precludes radiographic visualization of the gallbladder. Therefore, the visualization of multiple, small peripheral, fixed filling defects of varying size and uneven distribution should lead to the almost certain diagnosis of cholesterolosis. Conversely, a single fixed filling defect of less than one centimeter is still most often a cholesterol polyp but may represent a true adenoma.[1-3]

ADENOMYOMATOSIS is characterized microscopically by mucosal and muscular hyperplasia in which mucosal villi branch beneath the mucosa and pouch through the muscularis to form diverticula called Rokitansky-Aschoff sinuses. With radiographic contrast studies, the gallbladder is well visualized; its walls are interrupted by multiple small diverticula seen in profile (Fig 3). Often there is narrowing or stricture of the gallbladder where the diverticula are most numerous. A careful evaluation of stricture or septum formation within the gallbladder will often allow the diagnosis of adenomyomatosis to be made. The adenomyomatous "septum" or stricture may be located anywhere in the gallbladder and is usually more than 2mm in thickness, thus differentiating it from the Phrygian cap or the postural kink[4] (Fig 4).

The Rokitansky-Aschoff sinuses associated with the hyperplastic cholecystoses may predispose to stone formation by stasis and hypercon-

From the Department of Radiology, The Johns Hopkins Hospital. This work was supported in part by USPHS Grant No. 5T1-GM-1328.

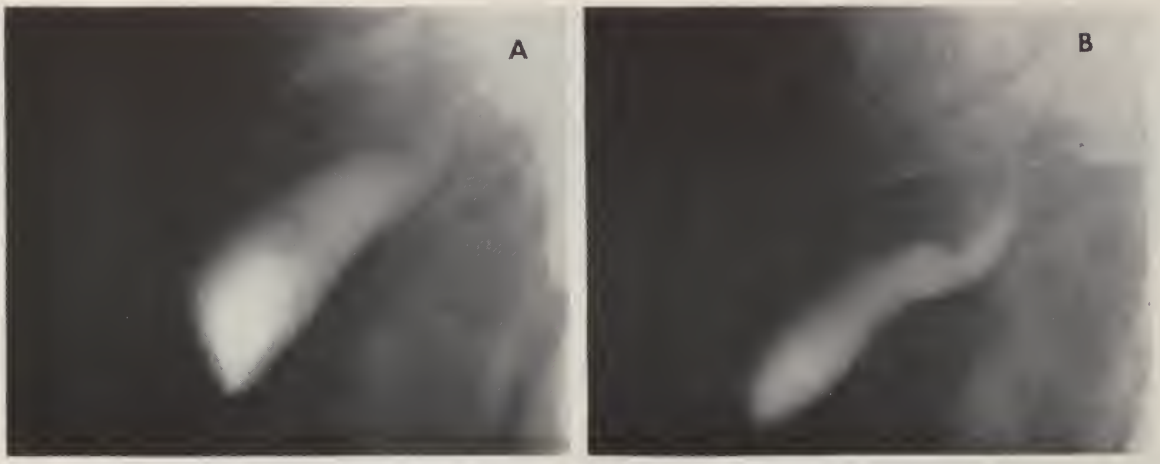


Fig 1
Cholesterolosis: Before (a) and after (b) fatty meal stimulus. Multiple fine, granular filling defects seen best after the fatty meal stimulus.

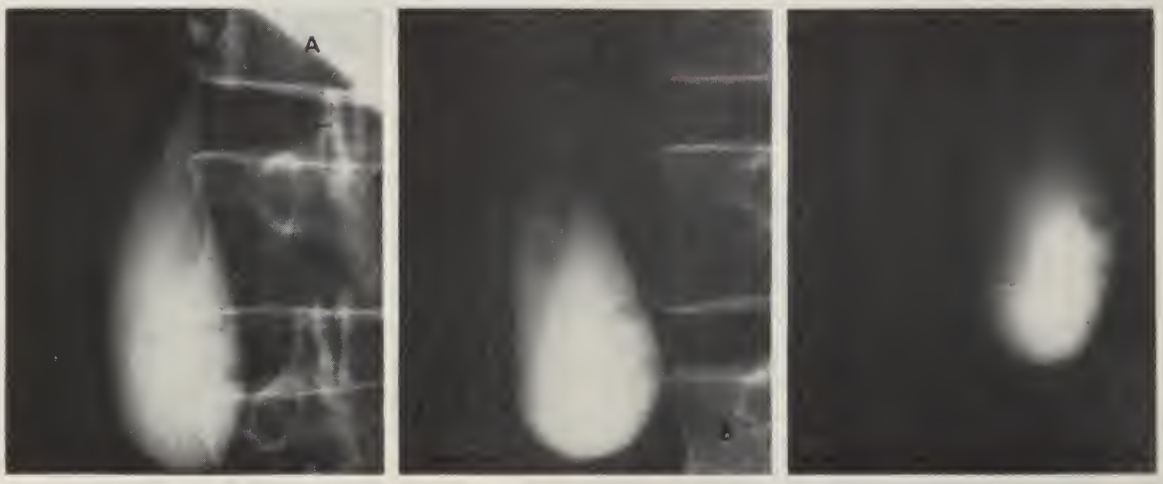


Fig 2
Cholesterolosis: Fixed filling defects ("polyps") which maintain constant relationship to gallbladder wall in supine (a) and erect (b) positions and after stimulation (c).

centration of bile with a secondary inflammatory response. The sinuses may not be appreciated radiographically until after contraction of the gallbladder following fatty meal stimulus.

A separate form of adenomyomatosis is the solitary adenomyoma, a fundal lesion with no neoplastic potential. When the gallbladder is distended, the mass is usually extraluminal and thus not evident. With contraction of the gallbladder, the mass projects into the lumen as a rounded intraluminal or intramural filling defect, and diverticula may be seen at that time[1, 5] (Fig 5).

NEUROMATOSIS is a non-neoplastic proliferation of the nerve fibers of the gallbladder. This lesion is quite common and is frequently

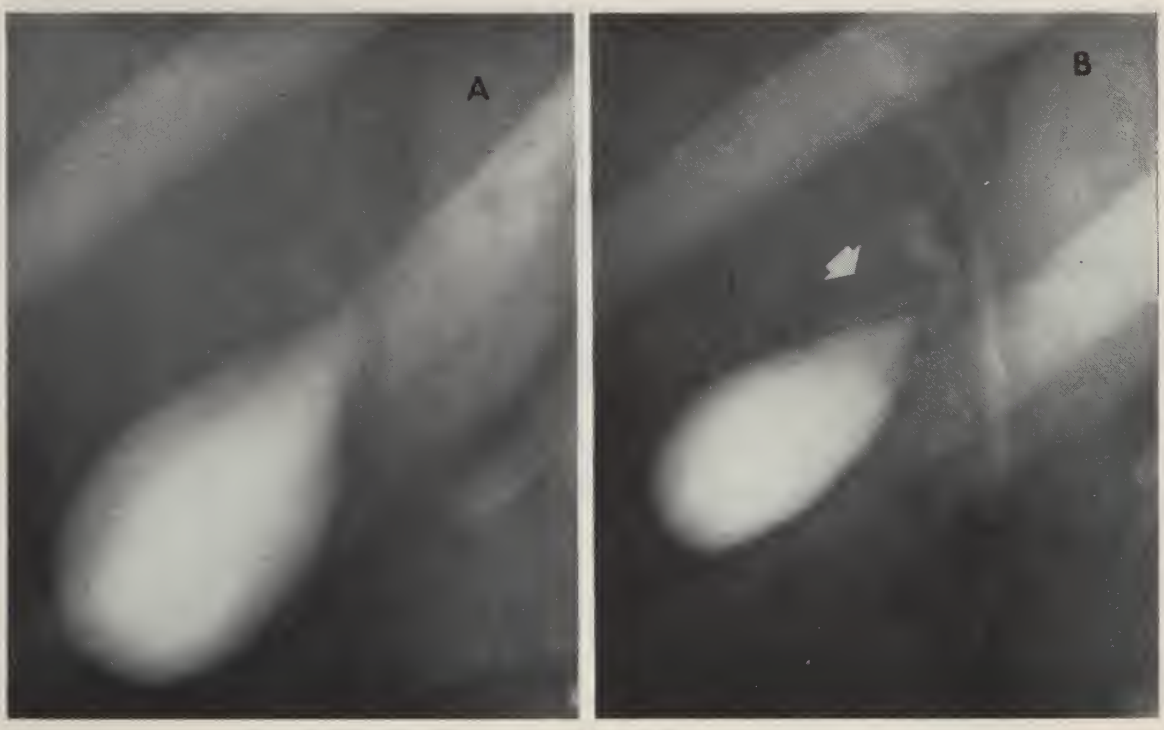


Fig 3
Adenomyomatosis: Before stimulation (a) diverticula poorly visualized. After stimulation (b) diverticula fill with contrast media and are visible (arrow).

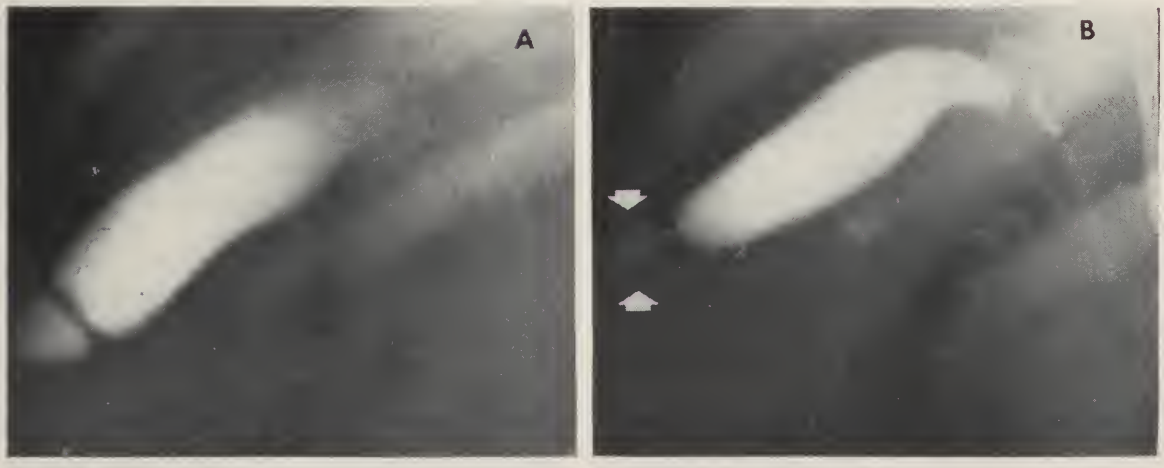


Fig 4
Hyperplastic cholecystoses (adenomyomatous septum) before (a) and after (b) fatty meal stimulus. Note thickness of septum and greater contraction of distal loculus than of proximal one after stimulation (arrow).

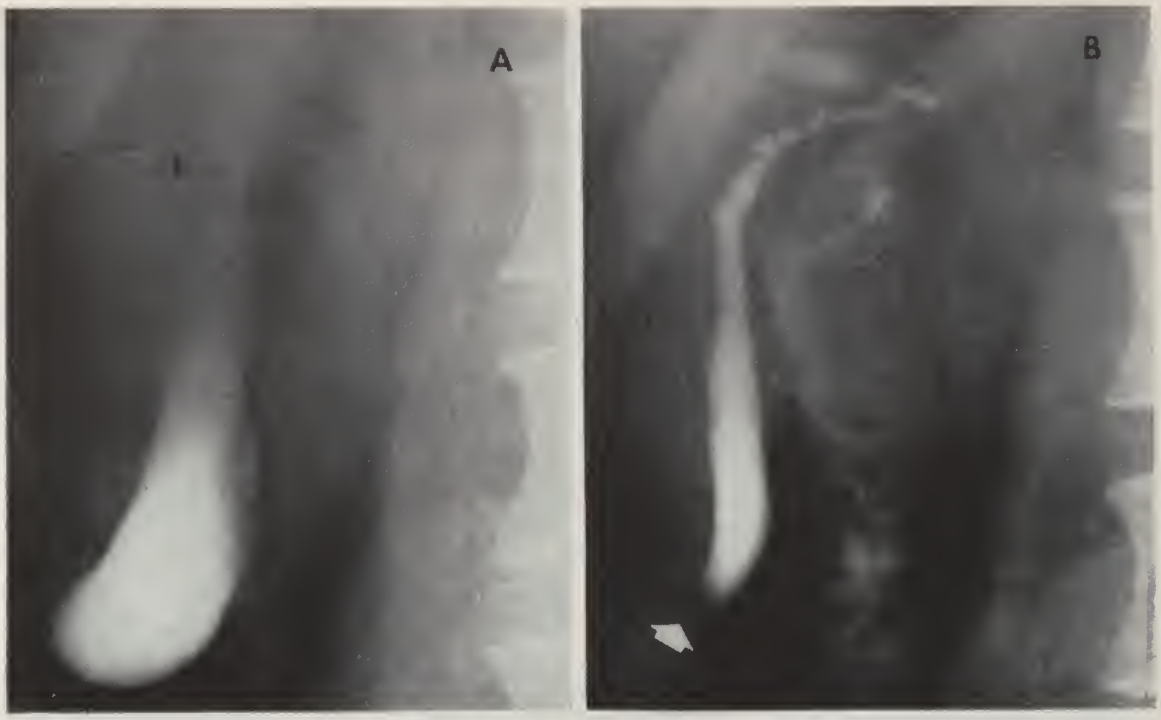


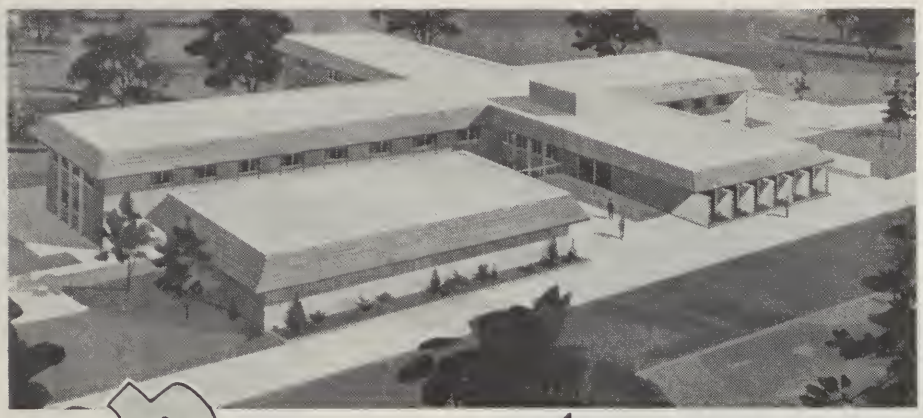
Fig 5
Fundal adenomyoma: Before stimulation (a) defect is extraluminal and not seen. After stimulation (b) defect becomes intraluminal (arrow). Note also hyperconcentration and hyperevacuation.

associated with other manifestations of the hyperplastic cholecystoses. Radiographically, neuromatosis is evidenced by hyperexcitability of the gallbladder, that is, by an unusually strong contractile response to stimulation. The presence of a superimposed neuromatosis probably explains the intense pain experienced by many patients with cholesterolosis or adenomyomatosis.[1]

RADIOGRAPHIC FINDINGS in the hyperplastic cholecystoses are not limited to observation of the filling defects or diverticula that correspond to the morphologic abnormalities. The functional radiographic findings due to the pathologic physiology involved are similarly striking. The mucosal hyperplasia causes an increase in the speed and intensity of concentration of contrast media: the neural hyperplasia produces an acceleration in response to stimuli; and the muscular hyperplasia initiates an exaggerated contractile response leading to rapid and excessive evacuation.[1] In more than 80% of patients with hyperplastic cholecystoses, the opacified gallbladder will be as dense as, or more dense than, the adjacent skeletal structures.[1] Frequently the hepatic and common bile ducts are visualized after the fatty meal.

Many patients with hyperplastic cholecystoses will have biliary calculi which will, to some extent, confuse the radiographic diagnosis and clinical management of their basic disease.

CLINICAL MANAGEMENT depends upon the presence or absence of biliary calculi and the severity of symptoms. The presence of stones usually is an indication for a cholecystectomy. Hyperplastic cholecystoses producing severe symptoms in the absence of stones probably is a valid indication for cholecystectomy; it frequently relieves symptoms.[6] Since the hyperplas-



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tic cholecystoses have no increased malignant potential, surgery is not imperative for the mildly symptomatic or asymptomatic patient. Although the policy of careful observation is well accepted,[3, 7] the occasional solitary cholesterol polyp may be operated upon since it cannot be differentiated with certainty from the true adenoma, which may have some potential for malignant degeneration.[2, 8]

Summary

The hyperplastic cholecystoses are a group of gallbladder conditions that are proliferative and degenerative rather than inflammatory or neoplastic. They are a manifestation of overwork or premature senescence of gallbladder tissue. The hyperplastic cholecystoses most commonly encountered are cholesterolosis, adenomyomatosis, and neuromatosis.

Radiographically, they are characterized by fixed, small filling defects, diverticula formation, or fundal defects in association with the functional triad of hyperconcentration, hyperexcitability, and hyperevacuation.

Clinical management depends upon the severity of symptoms and the presence or absence of gallstones. The probability of malignant degeneration is no higher than for that of a normal gallbladder.

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PKU LAWS, A MODEL FOR THE FUTURE?

SAMUEL P. BESSMAN, MD

Testing of children at, or shortly after, birth for mental retardation is a desirable objective if the test is reliable, and the therapy is not implied by law, and if we can be confident that no injury is done to children who are mistakenly diagnosed.

On November 21, 1965, as part of the 75th Anniversary Celebration of the Rosewood State Hospital, a panel of distinguished scientists considered biochemical problems in mental retardation. Dr. George Donnell reviewed studies in galactosemia, Dr. Alfred Knudson analyzed various genetic aspects of mental retardation, and Drs. George Jervis and Mary Efron discussed recent developments in diagnosis and treatment of phenylketonuria.

Some questions were raised during the talks on phenylketonuria and the question period afterwards tended to emphasize the growing misgivings of the medical community concerning this disease.

1. What evidence do we have that excess phenylalanine causes the mental retardation in phenylketonuria?

2. What evidence do we have that a child born with a high content of phenylalanine in his blood will be mentally retarded if he is not treated?

3. What are the blood test values to be designated as positive or negative for potential mental retardation? Dr. Efron suggested 20 mg% of phenylalanine as the lower limit of positive diagnosis, but Dr. Jervis and others mentioned lower and less exact standards, because there are no clear data.

4. What are the social implications for a family which is told that its child is potentially mentally retarded?

5. How effective is the restrictive diet in preventing mental retardation?

There are at present no unequivocal, or even scientifically valid answers to any of these questions, yet the public has been convinced that solid proof exists, and, on the basis of this impression, about 32 states have passed legislation, in most cases compelling evaluation of children by some chemical test.

The testing of children at, or shortly after, birth for mental retardation is a desirable objective if the test is reliable, and the therapy is not implied by law, and if we can be confident that no injury is done to children who are mistakenly diagnosed.

Unfortunately, at the present time it is not clear that any of these conditions are fulfilled. There is no assurance that a child who is born with a high blood phenylalanine will continue to have this high level throughout life. Both Dr. Efron and Dr. Jervis reported early variable and falling levels in a large number of children. The validity of the blood phenylalanine level as a gauge of the degree of mental retardation is very poor, and more and more children with normal mentality are being found who have had high blood phenylalanine levels throughout life. The numerical values obtained by different tests differ, the quality of the laboratories varies remarkably, and there is no consensus about what blood content of phenylalanine is diagnostic by any test. The only defensible statement which could be made at the present time would be:

This child was found to have a large amount of phenylalanine in its blood by two different tests. Phenylalanine might cause mental retardation because it is found in excess in the blood of ½ of 1% of mentally retarded children. Animal experiments may or may not show that phenylalanine is toxic for they are

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not conclusive. If we deprive this child of phenylalanine to the extent that his blood content drops to a range which we have not yet determined or agreed upon, we hope we can get information that we have prevented the mental retardation which the child may or may not get if he is not treated.

The most unusual aspect of the new laws is the legal assumption of the relation between a chemical test and the psychologic diagnosis of mental retardation. This would be serious if it were simply a problem of phenylketonuria, which is rare in itself, and only a minor cause of mental retardation. It becomes grave in its import when we note that the phenylketonuria programs are being offered as a model of legislation relating to many, if not all, forms of retardation "detectable" at birth.

Proponents of the mass testing programs claim that they will lead to new knowledge. As they are now constituted, PKU testing and treatment programs are unlikely to yield data of scientfic value. If we deprive all children found with excessive amounts of one amino acid or other then we shall have no knowledge of the course or natural history of disease. We shall claim "cures" for diseases which may never have occurred.

Doctors do not dare to withhold deprivation therapy unless they see severe growth failure or other clear evidence of immediate danger. The recent judgment obtained against those who did not diagnose and "treat" phenylketonuria is a case in point.

Surely, the poliovirus vaccines were far better documented and the prize far greater, but the approach has been more deliberate. Millions of children were tested and results were compared in many countries. There is still no law about polio. Much more is known about the biologic basis of heart disease and kidney disease in children than is known about the chemical mechanism of mental retardation, but no legislation has been proposed.

There are two general types of medical legislation—one is the attack on the financial problems of medicine, as exemplified by Medicare. The second is the crystallization into law of criteria for diagnosis and implication of therapy, such as the PKU laws.

It is important in the months ahead, as the drive for federal legislation gains momentum, that we sit back for a moment to weigh the consequences of premature action, both to the child and to society.



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Highlights

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The Bureau of Laboratories has been notified of the laboratory's accreditation by the College of American Pathologists, a professional society which conducts the only nationwide program for inspecting and accrediting clinical laboratories. Evaluation is made only when a laboratory is headed by a physician. To date this recognition has been given to only one other state health department laboratory. In order to receive accreditation, the laboratory submitted detailed information in response to a questionnaire; this was followed by an extensive review of all aspects of the laboratory's operations by a pathologist from a large District of Columbia hospital.

Dental Service for Handicapped

Implementation of a federally financed dental service for inpatients and outpatients at Kernan Hospital soon will be effected. Two dentists have been employed for two half days weekly; both have had excellent experience in remedial dentistry for physically and mentally handicapped children. A clerical-dental assistant is being sought to work three days a week.

Start of the project is pending the purchase of necessary specialized dental equipment and some structural changes in the hospital in which the dental facility is established.

Health Referrals for Military Rejectees

The Department is conducting a federally financed program to provide health referrals for young men who are medically disqualified for induction into the Armed Forces. A Health Department counselor informs the military rejectees of the examining physicians' diagnoses and endeavors to see that they are evaluated by their own private physicians, rather than through various local health facilities, in order to maintain the continuity of doctor-patient relationships. If necessary, referral to local health resources is suggested for rejectees who do not have private physicians, who do not understand the nature of their health problems, or who do not realize the importance of seeking necessary treatment or medical advice.

In a direct mailing and through the *Maryland State Medical Journal*, the Department is requesting private physicians who are consulted by the military rejectees to relay information needed for the compilation of statistics and the evaluation of the program's effectiveness. All information on individual cases will be considered confidential.

Chronic Disease Hospitals

Francis J. Borges, MD, a senior member of the University of Maryland Medical School faculty, has accepted the position of chief of medical and professional services at Montebello State Hospital. He will be responsible for patient care, teaching programs for residents and medical students, and research activities. It is hoped that the residency program at Montebello can begin on September 1, 1966.

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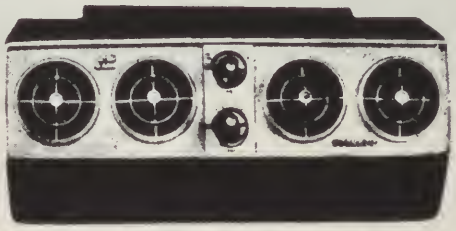
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Mr. Sachs Promoted

Mr. C. Edward Sachs has been promoted to director of the Bureau of Environmental Hygiene in the Baltimore City Health Department. He will supervise the activities of the Division of Community Sanitation and the Division of Rodent Control. This administrative position has been vacant since the death of Mr. George O. Motry on November 4, 1965.

Mr. Sachs, a native of Baltimore, attended Baltimore schools and graduated from the Johns Hopkins University, where he engaged in both pre-medical and civil engineering studies. In 1943 he became a senior sanitary inspector in the Division of Housing, then a subdivision of the Bureau of Environmental Hygiene. After a year's military service in 1945 and 1946 as an administrative specialist in the U.S. Army Air Force, he returned to the Bureau of Environmental Hygiene as sanitarian.

In 1952 Mr. Sachs transferred to the Bureau of Industrial Hygiene and in 1956 was promoted to chief of the Division of Industrial Hygiene Investigations. Later, after successive advancements, he became principal public health engineer in the Division of Air Pollution Control, where he was responsible for supervising the air pollution control work of the department.

Mr. Sachs performed important work in air pollution surveys before the Harbor Tunnel was built and more recently has assisted in the planning and conduct of the Metropolitan Air Quality Survey Program now in progress. He is a member of the National Association of Santitarians, the National Air Pollution Control Association, the American Association of Sanitarians, and the Maryland Public Health Association.

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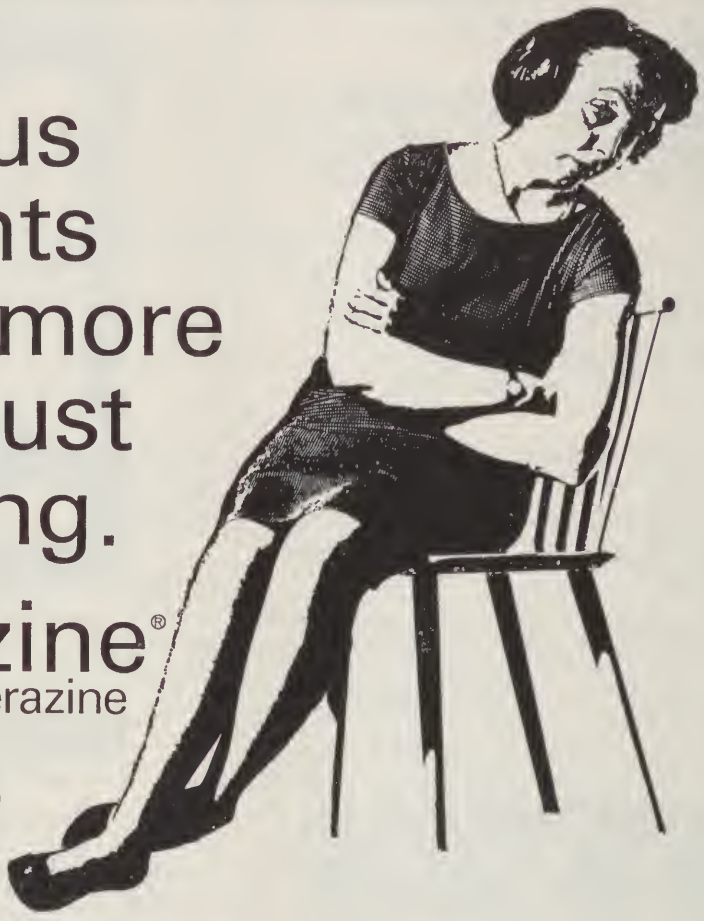
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Department of Mental Hygiene

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Kurt Gorwitz, Statistics Director

A Report to the 15 Southern States

The southern states* have made substantial progress in recent years in providing improved hospital services for their mentally ill; yet they still lag appreciably behind the rest of the United States, according to statistics published by the Office of Biometry of the National Institute of Mental Health.

Total hospital maintenance expenditures by the 15 states nearly doubled in this nine-year period (from $110,000,000 in 1956 to $215,000,000 in 1965), and average daily per patient expenditures are now more than twice the 1956 figure. However, since comparable changes have occurred in the other 35 states, the South's relative position has remained essentially unchanged. In fact, the South's daily average in 1965 of $4.96 was exceeded by at least 10% by each of the other 35 states. Available statistics indicate similar variations in the facilities for the mentally retarded.

Average Daily Per Patient Expenditure	15 Southern States	Rest of United States	Percent Difference
1956	$2.37	$3.53	—32.7
1959	3.11	4.66	—33.3
1962	3.91	5.91	—33.8
1965	4.96	7.30	—32.1
Number of Employees For Every 100 Patients			
1956	23.6	28.9	—18.3
1959	26.9	33.9	—20.5
1962	31.4	37.8	—16.9
1965	37.1	43.2	—14.1

This disparity does not reflect a lesser interest and support for mental hospital programs. Rather, it is related to the relatively lower economic level of most southern states. Latest figures released by the U.S. Department of Commerce indicate that per capita income in the South continues to be one-fourth lower than in the rest of the United States. This in turn has produced lower than

*Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

average per capita expenditures for all state services.

The South has been characterized as an area in transition. Gradual economic and social development can be expected to produce in the mental health field a concomitant continuation of the progress experienced in recent years. However, unless this is rapidly accelerated, much of the South will perpetually lag behind the rest of the United States.

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

The accompanying photo was taken during the semiannual meeting of the Maryland Association of Medical Assistants, which was held at the Sheraton-Belvedere Hotel on April 30.

Jose Martinez, MD, on the left, gave the welcoming address. Dr. Martinez is instructor in medicine and lecturer in the Department of Public Health Administration, Johns Hopkins University. He is also consultant in nuclear medicine for the Veterans Administration and associate director, Health and Welfare Fund, Amalgamated Clothing Workers of America. Dr. Martinez has given several talks on radioisotopes, before both the Maryland and the Washington Associations of Medical Assistants. His contributions have been most valuable.

Raymond Atkins, MD, center, was master of ceremonies at the banquet which followed the educational seminar. Dr. Atkins is assistant director of medical education at Church Home and Hospital, instructor in surgery and clinical anatomy at the University of Maryland, and instructor in the Outpatient Vascular Clinic, Johns Hopkins Hospital. He taught a class in anatomy and physiology for the medical assistants last year, which added much to the educational background of those attending. This course was particularly helpful to those members who took the examination for Certified Medical Assistant in June.

Dr. Atkins was appointed advisor to the Maryland Association of Medical Assistants for 1966 and 1967 by the Medical and Chirurgical



Faculty of Maryland. His term of office began at the meeting on April 30. The entire membership appreciates his willingness to accept this responsibility.

Jack Zimmerman, MD, on the right, was a speaker during the afternoon seminar. His subject was "Cardiac Pacemakers." Dr. Zimmerman is chief of surgery and director of medical education at Church Home and Hospital and associate professor of surgery at Johns Hopkins University. Dr. Zimmerman also has contributed to our meetings by acting as master of ceremonies at the banquet and installation ceremonies of the Baltimore City chapter of Medical Assistants on "Bosses' Night" in January. His ready wit makes him an ever-welcome addition to our gatherings.

Eleanor Scott, MD, chief of obstetrics at Church Home and Hospital, gave a most illuminating talk on "The Use of the Vacuum Extractor in Obstetrics." This is a fairly new development, and Dr. Scott's talk was particularly interesting to the many obstetric assistants in the audience.

Mr. Jerome Wilkenfeld, of the Hooker Chemical Corporation in Niagara Falls, NY, spoke on "Air Pollution," a topic of timely interest.

Captain Frank Voris, of the Medical Corps, U. S. Navy, gave a fascinating glimpse into the future of medicine through his work with space medicine and the medical programs connected with our astronauts and space explorations. He showed three memorable films, one of the "Walk in Space" and two official films of the NASA showing the Rendevouz in Space and the aborted Agena flight.

After the banquet, an installation ceremony for new officers was held. Officers are: president, Miss Betty Fern, secretary for Dr. Harry Kelmenson; president-elect, Mrs. Nell Chaney, secretary for Dr. Jack Zimmerman; secretary, Mrs. Lottie Wolfson, secretary to Dr. A. Cole; treasurer, Mr. John Komber, laboratory technologist for Dr. Henry Wollenweber.

Russell Fisher, MD, past advisor of the MAMA, initiated a standing ovation for the retiring president, Mrs. Katherine Kousouris, secretary for Dr. Charles Doeller. Under her leadership, many changes and gains in membership were accomplished.

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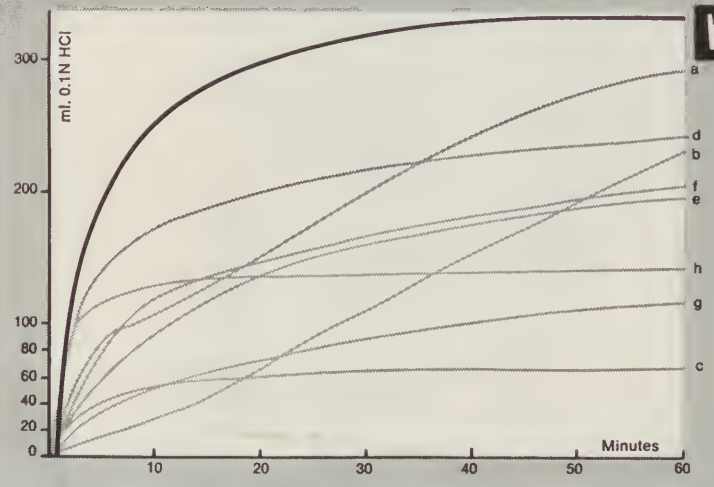
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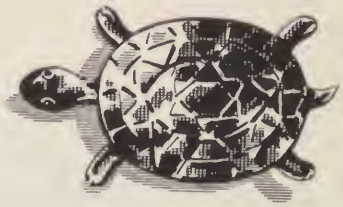
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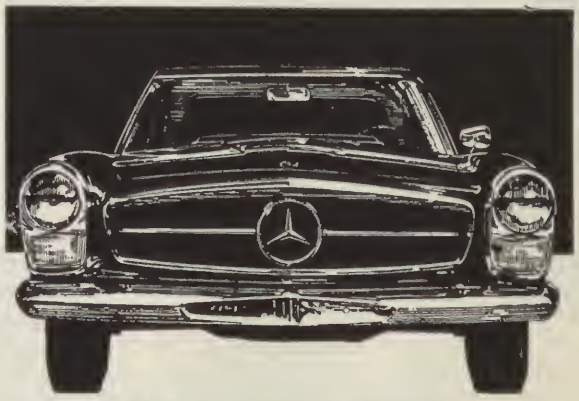
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EXECUTIVE SECRETARY'S NEWSLETTER

August, 1966

IT'S NOT TOO LATE!!

It's not too late to make your reservation for the Semiannual session on September 9, 1966. Fun for all at the Diplomat Motel, Ocean City. If the Diplomat can't accommodate you, arrangements have been made for your reservation to be sent to nearby motels.

COMING EVENTS

**** TRAFFIC SAFETY**

An all-day Seminar on the Medical Aspects of Traffic Safety is scheduled for **Wednesday, October 12, 1966.** Gubernatorial candidates, the Governor and others have already indicated their acceptances to appear on the program. Full details will be sent to all members shortly.

**** MEDICAL ETHICS**

An all-day session on Medical Ethics has also been scheduled for Saturday, October 15, at the Med-Chi Building. Primarily aimed at residents and interns who obtain very little of this during their student days, the sessions are open to all members.

Topics will range from "The Ethical, Legal and Moral Responsibilities" of physicians to a panel which will discuss "On Entering Practice."

Full details to all members shortly.

PLEASE TAKE NOTE

It has been brought to the attention of the Faculty office that physicians throughout Maryland are being solicited for $58.00 for a "listing in a Classified Directory."

This company, based in California, operates within the confines of the law in all states throughout the country. A careful perusal of the "invoice" indicates that it is a "solicitation", and not a "bill, invoice or renewal".

Physicians are cautioned against believing that this represents an organization officially recognized by medical groups. Physicians are also cautioned that the Medical Practice Act of Maryland prohibits advertising of any sort by physicians.

NEW LABORATORY RULES AND REGULATIONS

New rules and regulations for laboratories in Maryland have been published and are effective on October 1, 1966.

In essence, certain standards and educational qualifications will be required of personnel operating such establishments.

Physicians are reminded of the ethical standards established by the Faculty in connection with services offered by laboratories. It is our understanding that a representative of the U. S. Senate Antitrust and Monopoly Committee is now conducting an investigation of laboratory operations in Maryland to ascertain:

ANTITRUST INVESTIGATION

1. Which, if any, physicians bill for services not actually performed in their offices and by their own personnel.

2. Which physicians, if any, have a "contract" arrangement with laboratories whereby they pay a flat rate per month to the laboratory for an unlimited amount of services and, in turn, bill the patients for these services.

3. Physicians who are or have permitted their names to be used as a "front" for so-called lay laboratories.

NEWS NOTES

Pediatricians whose names are not on the rolls of the Maryland Pediatric Society are urged to contact the current secretary, Clewell Howell, M.D., 102 Allegany Ave., Towson 21204. Members of this group who have recently moved are also asked to advise the Secretary of their new addresses.

John C. Harvey, M.D., was named Professor of Medicine in the Johns Hopkins University on July 1.

New Diplomates of the American Board of Anesthesiology include Yavuz V. Kent, M.D., Pikesville; and George H. Friskey, M.D., Baltimore.

John Sargent

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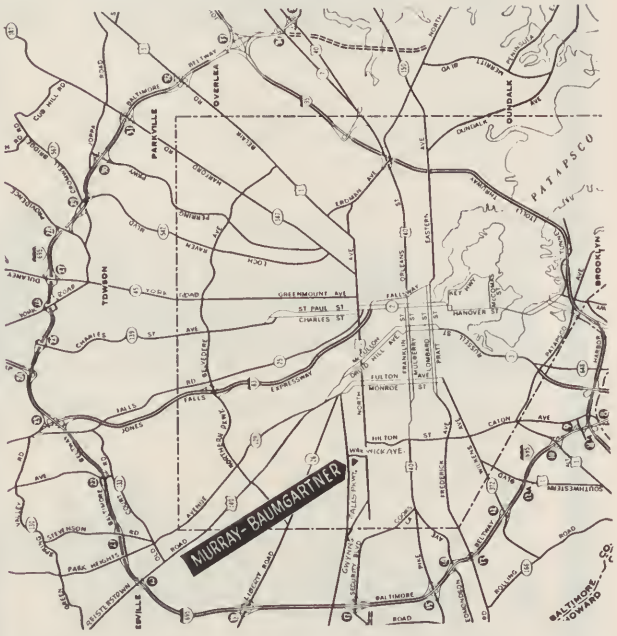
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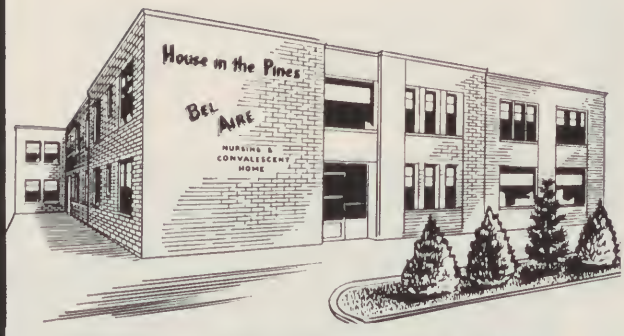
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THE MARYLAND-DISTRICT OF COLUMBIA SOCIETY OF ANESTHESIOLOGISTS

Annual meeting, Sunday, September 18
U. S. Naval Medical Center, Bethesda

PROGRAM

1:30 PM annual business meeting

2 PM "*PRACTICAL PULMONARY PHYSIOLOGY*"

Sol Katz, MD, chief, Medical Service, Veterans Administration Hospital, Washington, DC; professor of medicine, Georgetown University School of Medicine.

Peter C. Luchsinger, MD, chief, Cardiopulmonary Physiology Research, Veterans Administration Hospital, Washington, DC; associate professor of medicine, Georgetown University School of Medicine.

Hall G. Canter, MD, assistant chief, Medical Service, Veterans Administration Hospital, Washington, DC; assistant professor of medicine, Georgetown University School of Medicine.

Donald P. Schilder, MD, director, Emphysema Unit, Veterans Administration Hospital, Washington, DC.

4-5 PM cocktails

5 PM buffet dinner

MARYLAND STATE DENTAL ASSOCIATION

September 18-21
Lord Baltimore Hotel

Four speakers (one half hour each) will talk on timely dental topics each day. In addition 30 table clinics will be presented. On Sunday, September 18, the annual seafood dinner party will be held from 1 to 5 PM at the Oriole Gun Club. The President's Reception and Dance will be held at the Lord Baltimore Hotel on September 19 from 7:30 PM to 1 AM.

AMERICAN COLLEGE OF PHYSICIANS
Postgraduate Courses 1966

The courses run from three to five days and are held in cooperation with medical schools and teaching institutions throughout the United States. The concentrated courses are aimed at providing practicing physicians with formal instruction in new developments affecting the diagnosis and treatment of diseases. The courses are part of the College's continuing education program to help internists keep their medical knowledge and skills current.

The courses are open to all physicians. However, in each case enrollment is limited, and priority is given to members of the American College of Physicians.

September 28-October 1 *Advances in Cutaneous Medicine,* Mayo Graduate School of Medicine, University of Minnesota, Rochester.

October 3-7 *The Care of the Critically Ill Medical Patient,* State University of New York College of Medicine, Syracuse.

November 7-11 *Endocrine and Metabolic Disorders,* The State University of New York, Downstate Medical Center, Brooklyn.

November 14-18 *Newer Aspects of Experimental and Clinical Allergy,* Harvard University Medical School, Boston.

November 28-December 2 *Progress in Gastroenterology,* University of Pennsylvania School of Medicine, Philadelphia.

December 5-9 *What the Internist Should Know About Cancer,* College of Physicians and Surgeons of Columbia University, New York.

December 14-17 *Infectious Diseases,* University of Pittsburgh School of Medicine and Medical Center.

SOUTHERN MEDICAL ASSOCIATION
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#2 EYE, EAR, NOSE & THROAT
December 1
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#3 NEUROPATHOLOGY FOR PATHOLOGISTS
December 5-10
Given at the practical level and including basic neuropathology, trauma, tumors, infections and degenerative diseases; surgical neuropathology; the neurological clinicopathological conference; and practical drill in cutting, blocking, staining, and microscopic study of provided specimens.

#4 SURGICAL PHYSIOLOGY
December 15
Preoperative and postoperative physiology, functional derangements, and management of the clinical problems commonly presented by the surgical patient will be discussed.

#5 ADVANCES IN MEDICAL SCIENCE
January 11-April 15
(Wednesdays, 3-5 PM)
Designed for physicians in practice who wish to keep abreast of the important advances in medical science. Emphasis is placed on a basic scientific approach to an understanding of the more common clinical problems and their management.

#6 DERMATOLOGY
January 19
A clinical session in which many dermatologic disorders will be seen and examined by the attending physicians, followed by presentation and discussion of the problems of diagnosis and management of each entity.

#7 CLINICAL ANATOMY
February 1-May 24
(3 hours/day; 2 days/week)
Emphasizing the practical application of anatomy and anatomical principles in physical and x-ray diagnosis. Anatomical knowledge is related to the use of needling in performing diagnostic procedures and in treatment. The course is directed toward both the medical man and the surgeon. It is an aid in preparation for the American Board Examination.

#8 GYNECOLOGY
February 9
Designed to be of interest to both general practitioners and specialists.

#9 DIABETES
March 2
Presenting recent advances of great practical interest in this field.

#10 HEMATOLOGY
March 16
A review of current trends and investigative efforts in selected areas of hematology and their implications, both practical and theoretical.

#11 IN-SERVICE PROGRAM
The enrollee spends a week in pre-selected department, accompanying members of the department on rounds, conferences, clinics, etc. Time is arranged upon application. This course will not be available during the months of May, June, July.

Advance registration is requested on all courses.

Category I Credit of Academy of General Practice is allowed on all courses.

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HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

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December 12-14—17th Hahnemann Symposium: "Renal Failure," Marriott Motor Hotel, Philadelphia

AMERICAN COLLEGE OF OBSTETRICS AND GYNECOLOGY
DISTRICT IV

October 17-19

Annual meeting, Marriott Motor Hotel, Atlanta. Conference on Obstetric, Gynecologic, and Neonatal Nursing, Dinkler Plaza Hotel, Atlanta.

AMERICAN HEART ASSOCIATION

September 21-23

Three days of cardiology, University of Iowa, Iowa City; cosponsored with Iowa Heart Association.

September 25-30

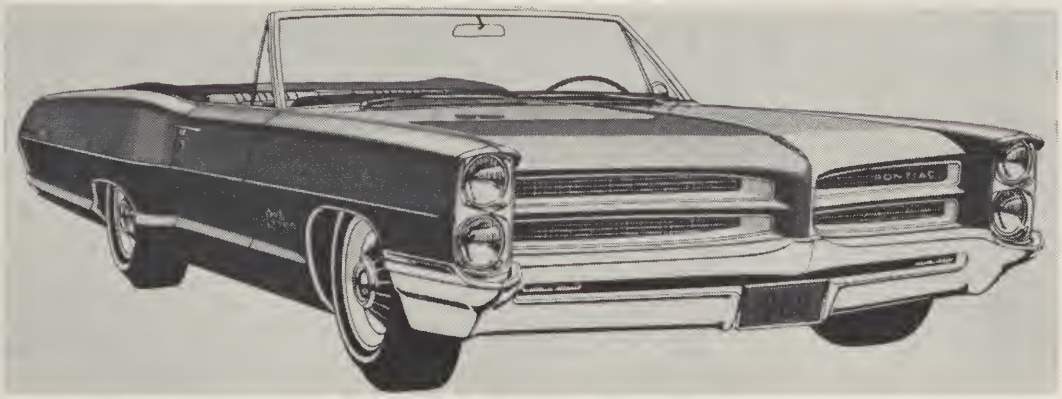
Third International Congress of Nephrology, Washington Hilton Hotel, Washington, DC; cosponsored with District of Columbia Heart Association.

October 21-27

Annual meeting, New York City. Scientific sessions, October 21-23; assembly, October 24-25; staff society, October 25-27.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

COUNCIL, JUNE 9

1. A portrait of the late Edgar B. Friedenwald, MD, presented by his son, was accepted on behalf of the Faculty by the Council Chairman.

2. Henry P. Laughlin, MD, was elected to fill the unexpired term of Richard D. Bauer, MD, as councilor from the South Central District.

3. Approval was given to charging to the Educational Fund expenses in connection with the regional Medicare seminars.

4. Physicians' Defense was approved for members requesting it.

5. The Council was advised of settlement of a case.

6. The resignation of George H. Yeager, MD, as editor of the Journal was accepted with regret and expression of appreciation for his many years of service.

7. Approval was given to the proposed immunization program of the State Health Department with the following stipulations: 1) that only the measles vaccine be provided free; 2) that the publicity program will encourage the public to obtain the immunizations from their family physician and not state that they are available without charge from the State Health Department clinics. It is understood that the approval is limited to measles, DPT, smallpox, and polio vaccines and that the Health Department will specify the exact type of measles vaccine to be used.

8. A recommendation that funds be allocated to reimburse speakers for travel expenses to meetings in distant points of the state was denied.

9. A recommendation asking Blue Cross to provide benefits for care of patients with chronic respiratory disease in approved specially equipped nursing homes was ratified.

10. A recommendation that tuberculosis hospitals in the state institute treatment of alcoholism in their alcoholic patients was adopted.

11. The recommendation that renegotiation of the Dependents Medical Care contract be made only on the basis of usual and customary fees was endorsed.

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12. A recommendation condemning the practice of various state and local agencies to determine fees paid to physicians without consultation with the medical profession and notifying these agencies of the Faculty's desire to participate in discussing such fees was adopted.

13. A suggestion that the Council and the Executive Committee call upon the Fee Schedule Committee for guidance in matters pertaining to fees in all areas, and particularly in matters dealing with Titles 18 and 19 of PL 89-97, was noted and will be complied with whenever possible.

14. The Council approved the sending of a letter to the State Departments of Health and Mental Hygiene urging that meetings of committees and councils on which Faculty members serve be scheduled at more convenient times.

15. Recommendations of the Program and Arrangements Committee were adopted: 1) that the 1967 scientific sessions be held April 19, 20, and 21 and the House of Delegates meetings on the morning of April 26 and the afternoon of April 29; 2) that a seven-day Caribbean cruise convention be held in conjunction with the 1968 Annual Meeting.

16. A representative from The Johns Hopkins Medical Institutions discussed the question of a branch or satellite hospital in Howard County. A motion was adopted that the President appoint a committee to confer further with Johns Hopkins and other interested parties concerning this; that this does not imply approval of the concept of a closed panel operation; that the Faculty reiterate its policy of favoring free choice of physician over the closed panel plan; and that the desires and previous action of the Howard County Medical Society be considered.

17. A representative from the Eastpoint Medical Center explained its operation and organization. In subsequent discussion, the matter was brought out that the Faculty should make clear at all times its position concerning free choice of physician versus closed panel practice.

18. A resolution was approved asking the Board of Medical Examiners to check with the Faculty and with knowledgeable people in the community before restoring a physician's license or releasing him from probation.

19. A recommendation was approved that all physicians be reminded of the provisions of Federal Trade Commission Rule #7 dealing with acceptance of kickbacks from opticians; also physicians should be aware of the illegality of physician-owned pharmacies.

20. A request from the Med-Chi Insurance Trust to plan a retirement program for Faculty members, in lieu of the Medre program which was adopted but not implemented, was tabled. The Medre Fund is working out details of its own program; however, the Med-Chi Trust might work with the Medre Fund trustees and coordinate activities.



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(see previous page)

Maryland State Medical Journal
Vol. 15, No. 8
August, 1966

IMMUNIZATION SCHEDULE

Maryland's program of immunization of infants and preschool children has recently received a substantial grant from the Public Health Service under the Vaccination Assistance Act. This grant enables the State Department of Health to supply certain vaccines, personnel, and educational materials for a project aimed at protecting all children against diphtheria, polio, whooping cough, tetanus, smallpox, and measles by the time they are ready to enter school and preferably during the first 15 months of life.

Vaccines which are safe, effective in producing immunity, relatively cheap, easily administered, and which usually do not cause severe systemic reactions are now available for these six diseases. It is believed that when 85% or more of a population has been vaccinated against any one of these diseases, there is little danger of an outbreak. Obviously, high levels of immunity in the population can be reached and maintained only by a continuing program of vaccinations of: 1) the backlog of unvaccinated, especially children of preschool age; 2) children born in the area, beginning when at two months of age; 3) unvaccinated persons moving into the community; 4) booster injections to vaccinated persons at recommended intervals.

Since most of these diseases are more dangerous to children in the first years of life, it is important that the child be given adequate protection beginning as soon after he reaches the age of two months as is convenient and being completed as quickly as is compatible with the recommendations governing the administration of each type of vaccine.

The following schedule is up-to-date insofar as latest available recommendations from recognized authorities are concerned.

Recommended Schedule of Primary Immunizations

Approximate age	Interval between doses	Vaccines	
2 mos.	Start	DPT, OPV[3]	
3 mos.	1 mo.	DPT	
4 mos.	1 mo.	DPT, OPV[3]	
6 mos.	2 mo.	Smallpox	
12 mos.		Measles	
15 mos.		DPT, OPV[3]	Boosters Observing minimum intervals between doses.
5 to 6 yrs. (Before entering school)		DPT, OPV[3] Smallpox	
10 yrs.		DT Smallpox	
15 yrs.		DT Smallpox	

ABBREVIATIONS: DPT—diphtheria, pertussis, and tetanus vaccine. OPV[3]—trivalent oral polio vaccine. DT—adult type diphtheria and tetanus vaccine.

Only well children should be vaccinated.

Oral polio vaccine (OPV) is preferably administered in the fall, winter, or spring months; however, should the child's dose fall due in a summer month and difficulties arise for arranging a return

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visit to the physician or clinic, the dose should be given regardless of the season.

The triple vaccine OPV[3] is preferable to the monovalent type.

OPV should not be given to persons who have passed their nineteenth birthday. For these individuals the Salk vaccine should be given in the usual series of three doses and a booster. This rule should be followed in vaccinating pregnant women against polio.

Smallpox vaccine should not be given to children with eczema or any other type of dermatitis or to children whose siblings have a skin disease.

Do not vaccinate children simultaneously with measles and smallpox vaccine, or measles and OPV, or OPV and smallpox. There should be an interval of eight weeks between each of these vaccinations.

Smallpox, measles, or OPV may be given simultaneously with DPT.

DPT is not given beyond the age of 6 years because of the reaction which may be produced by pertussis vaccine. The *adult type* DT should be used for persons 7 years and older.

When a child begins the series of primary vaccinations at an older age than two months, the above schedule may be shortened provided the minimum intervals of one month between doses of DPT and eight weeks between doses of OPV, measles, and smallpox are observed.

If primary DPT series is interrupted for more than six months, the series should be begun again. If the primary OPV[3] series is interrupted for more than the scheduled interval, it is not necessary to begin the series again. Complete the three doses regardless of the time which has elapsed since the last dose, observing the minimum interval of eight weeks between doses. The objective in all vaccinations is to give the child the maximum number of antigens in the shortest allowable time.

The Maryland Immunization Project, with the endorsement of the Medical and Chirurgical Faculty of Maryland, will emphasize particularly immunization against measles during the early months of operation. Special instructions regarding the administration of measles vaccine, issued June 1, 1966, may be obtained from the Division of Epidemiology of the State Health Department or your local health department.

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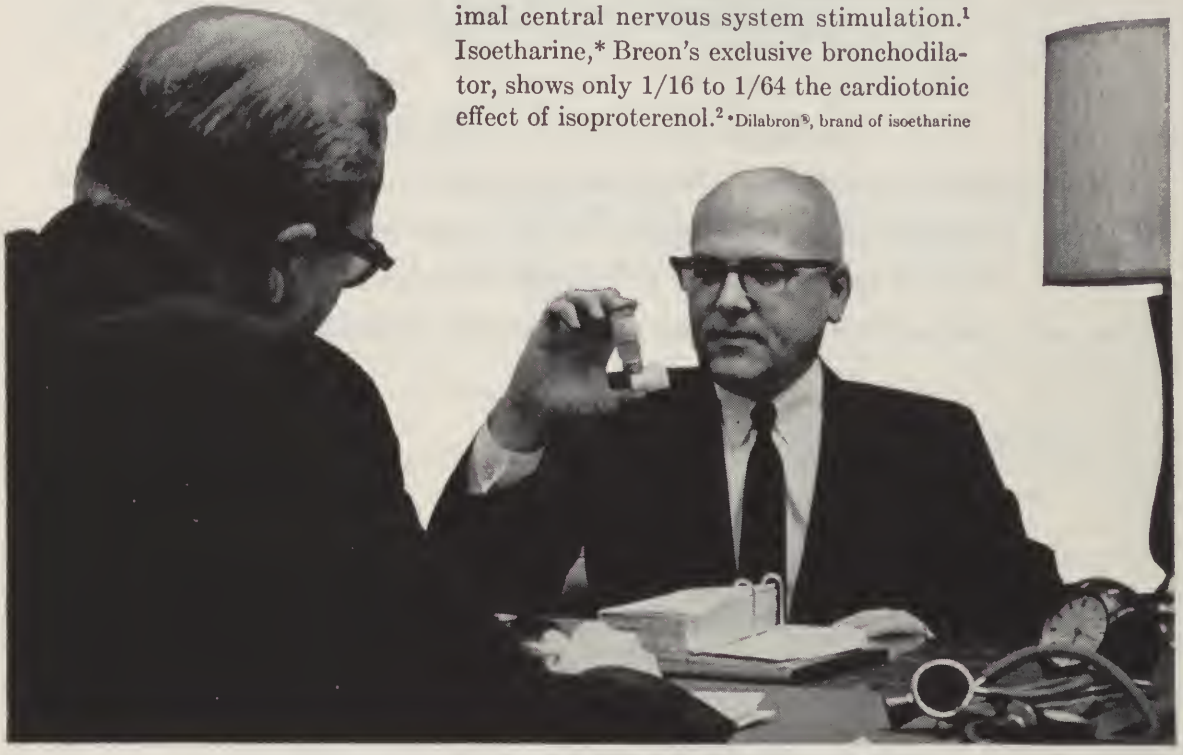
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ACUTE THROMBOPHLEBITIS AND ITS COMPLICATIONS

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Chief of Surgery, Union Memorial Hospital

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Acute thrombophlebitis and its complications are often fatal and always incapacitating. Treatment should be directed at prophylaxis. Measures to obviate trauma, overcome stasis, and provide anticoagulant therapy should be instituted in all bedridden cardiac, severely traumatized, and immobilized patients, as well as in those who have had previous attacks of thrombophlebitis. Prophylaxis and therapy are achieved by essentially the same means, but the indications for their use are different. Surgery plays a relatively minor role in the treatment of this disease and its complications. Femoral thrombectomy is indicated in cases of massive ileofemoral thrombophlebitis. Pulmonary thrombectomy may be indicated in cases of massive pulmonary embolism. The postphlebitic syndrome, a distressing but not lethal complication, is best treated by conservative measures. Phlegmasia cerulea dolens should be attacked surgically by thrombectomy followed by anticoagulant therapy.

Acute thrombophlebitis has plagued mankind persistently in the past centuries. In spite of continuous interest in the pathophysiology and clinical manifestations of the disease, there is no evidence to indicate that it is on the decline. On the contrary, Ochsner's[16] statistics show an actual increase of the disease in his clinic. Even more distressing is the fact that in a significant percentage of cases the complication of a fatal pulmonary embolism is the first manifestation of the disease.

Definition.—We shall define the term "acute thrombophlebitis" as any form of intravenous clotting in the deep venous system, with or without endothelial irritation or inflammation. We believe that phlebothrombosis is but a different clinical manifestation of essentially the same pathologic process and hence will not use this term.

The term "acute superficial thrombophlebitis" will be used when referring to thrombosis of the superficial veins.

Etiology.—Endothelial irritation, venous stasis, and hypercoagulability have been recognized since the days of Virchow as the major causes of throm-

Delivered before The Maryland Chapter of The American College of Surgeons, September, 1963.

bophlebitis. There is no evidence to suggest that one of these factors plays a more important role than the others.

Experimentally, one can produce thrombophlebitis by endothelial irritation, whether by mechanical, chemical, or bacterial insults. However, in most clinical cases, a history of such trauma is lacking.

The importance of stasis is well appreciated. Sevitt[20] and Roberts[18] have found that length of hospital stay was a contributing factor to the venous stasis. Byrne[3] attracted the attention of the medical world to the element of heart disease as a common denominator in the production of stasis. Age is also an important factor, producing general debility and consequent prolonged inactivity.

Blood hypercoagulability probably plays a significant role in causing this disease. Physiologic, pathologic, and pharmacologic factors have been incriminated, but the exact mechanism of their action has not been clarified. Ochsner[15] has found the thromboplastin generation test to be helpful in identifying patients predisposed to intravascular thrombosis. Because it is expensive and time consuming, this test is impractical for most hospitals and for most patients.

Symptoms and Signs.—The classical signs and symptoms of acute thrombophlebitis are fever, swelling of the extremity, and pain. The temperature elevation is usually slight and is caused by a pyrogenic response to the breakdown of white cells in the thrombus. Swelling is the most frequent finding and is caused primarily by the thrombus occluding the vein and the associated venospasm. The stasis produces anoxia, capillary permeability, and extravasation of fluid into the tissue spaces. The associated arterial spasm reduces arterial flow, which in turn leads to lymph stasis and more edema. Pain may be severe or merely constant. It is caused by endothelial irritation, venous dilatation, and congestion. Anoxia secondary to capillary stasis and smooth muscle spasm are also contributing factors.

Frequently the disease process is silent; the first indication of its presence may be the manifestation of a complication.

Diagnosis.—The diagnosis of thrombophlebitis is made clinically. Seldom does one receive any help from laboratory or ancillary studies. A classical case of massive swelling of the extremities, calf pain, and low-grade fever is easy to diagnose, but this is the exception rather than the rule. Homan's,[10] Lowenberg's,[11] and Peabody's[17] signs are of some aid, but they are often negative. We firmly believe that every case of unilateral swelling of the lower extremities or postoperative lung infiltrate, even in the absence of other signs, should be considered as evidence of thrombophlebitis unless another cause can be found and treated.

Prophylaxis.—A disease whose clinical course may be ushered in by death in a significant number of cases can be treated effectively only by good prophylaxis. Prophylactic treatment must be directed toward the prevention of hypercoagulability, stasis, and endothelial irritation.

It is not practical to prevent coagulation in all surgical patients, but it is practical to prevent stasis. Many methods have been suggested. Elastic support of the lower leg postoperatively has been popular in many institutions, but its benefit is questionable. McLachlin's[13] papers prove conclusively that elevating the foot of the bed 15 degrees is the best way to avoid stasis. We believe that all beds of surgical patients, even those in the recovery room, should be kept with a 15 degree foot elevation unless the patient's condition contraindicates this. For patients with a failing heart, a 15 degree flexion of the hip is beneficial but not as effective as foot elevation.

Anticoagulation for surgical patients may be indicated in the prophylaxis of thrombophlebitis, but we do not advocate doing this promiscuously or routinely. The indications for its use are: 1) a previous bout of thrombophlebitis, 2) confinement to bed for long periods of time with multiple fractures of the lower extremities or long leg casts, 3) obese patients undergoing major surgery, 4) known cardiovascular disease. Patients in the last group not only are more prone to develop thrombophlebitis but also tolerate emboli poorly. Contraindications to anticoagulant prophylaxis include surgery of the brain and operations requiring extensive dissection.

Treatment of Thrombophlebitis

The aims of treatment are: 1) to bring about the subsidence of acute symptoms of pain and swelling as soon as possible, 2) to limit extension of the disease, 3) to prevent embolization, 4) to minimize the postphlebitic sequelae, and 5) to

avoid recurrence. The approach to treatment is threefold:

1. Mechanical.—A regimen of rest, elevation, and support. The leg should be wrapped securely from the foot to the knee. The foot of the bed should be elevated 15 degrees according to McLachlin's principles. If there is massive edema, the leg itself should be raised to 45 degrees by flexing the hip. Occasionally it is necessary to suspend the leg from an overhead frame. The patient should stay in bed with the foot elevated until the pain subsides or until adequate anticoagulation is achieved. He is then allowed to walk, but he should not sit with legs dependent. There is no merit in applying heat or cold to the extremities.

2. Drug therapy.—Once the diagnosis of thrombophlebitis is made, anticoagulant therapy should be started. Heparin is the drug of choice because of quick initial therapeutic level, prompt clinical response, and safety of control. The recurrence rate of the disease and embolization is three times as great with antiprothrombin drugs as with heparin, and the antiprothrombin drugs are not as effective in protecting the injured endothelium.

Although the dosage of heparin must be varied with the patient's drug sensitivity, his size, and the extent of the disease, the following schedule is a useful guideline to therapy. The initial dose of 100mgm is given intravenously in order to achieve a rapid therapeutic blood level. Thereafter it is administered by deep subcutaneous injections. The dose is adjusted to maintain clotting time between two and three times normal. The usual dose is 50-75mgm, given every six hours. After a steady level of anticoagulation is attained, the clotting time need be measured only once a day.

Antibiotics or chemotherapeutic agents are used only if a septic process is present or if massive edema has been present for a long time. In the latter situation, we use them to prevent cellulitis, since edema fluid is a good medium for bacterial growth. We don't use enzymes, for they may be toxic, they are unpredictable in their effects, and are expensive. Undoubtedly, in the future, some enzymes will be isolated which will activate those within the thrombus itself and will be helpful in the resolution of the process. Phenylbutazone (Butazolidin) and other anti-inflammatory agents are used only in superficial thrombophlebitis. It has not been proved, to our knowledge, that phenylbutazone added to anticoagulant therapy has any greater benefit than anticoagulant therapy alone.

Recently, dextran became another therapeutic agent in the treatment of thrombophlebitis. Bernstein[1] and coworkers have shown that in dogs dextran reduces venous thrombosis produced by chemical irritants. Both 45,000 molecular weight and 75,000 molecular weight Dextran have been used in the treatment of human thrombophlebitis with the best results in the early phlebitis. Cox[7] and his group used it for three days, giving 500cc each day intravenously. They reported good results in nearly 90% of the early cases.

3. Surgery.—Surgery has a limited place in the treatment of acute thrombophlebitis. Lumbar sympathetic block in the early stages might reduce the pain and limit the swelling. Thrombectomy is indicated in massive ileofemoral thrombophlebitis if the patient is seen early in the course of his disease.[9] It will, undoubtedly, reduce morbidity and the ravages of postphlebitic syndrome. Other surgical procedures are warranted only for treatment of complications of the disease.

Treatment of Acute Superficial Thrombophlebitis.—This usually is a self-limiting disease which is best treated by conservative measures. Ice packs to the involved area will relieve the pain. Phenylbutazone will hasten resolution of the inflammation, and elastic support will prevent extension of the process. Occasionally, its course may be protracted. In this case, a proximal ligation and excision of the diseased segment of the vein is indicated.

Complications of Thrombophlebitis

The most dreaded complication of thrombophlebitis is pulmonary embolism, which may appear early or late in the course of the disease. Any patient with pleuritic-like pain, bloody sputum, hypotension, or a lung infiltrate should be suspected of having an embolic episode. Diagnosis is often difficult, especially since the x-ray or ECG findings are not specific. Recently, radio-isotope scanning using albumin tagged with I^{131} and Cr^{51} have shown great promise in the detection of emboli. Pulmonary angiography has also been used as a diagnostic test. The serum enzyme levels are usually not helpful in acute cases.

The treatment of pulmonary embolism should be conservative. It is geared to supporting the

failing cardiopulmonary systems and includes oxygen, vasopressors, digitalis, atropine, and anticoagulants. In institutions where a trained cardiovascular team and a cardiopulmonary bypass are available, pulmonary embolectomy has been successfully performed. This treatment should be reserved for patients who survived the initial massive pulmonary embolization long enough to institute cardiopulmonary bypass and who would not be expected to survive without pulmonary embolectomy. Here, also, treatment should be geared to preventing further embolization. It should include long-term anticoagulant therapy and partial or total interruption of vena cava in recurrent cases.

The second major complication of thrombophlebitis is the postphlebitic syndrome, referred to as the ball-and-chain, which remains as an aftermath of the disease. This is a common and a most incapacitating complication. It is manifested by hyperpigmentation, swelling, secondary varicosities, ulcerations, stasis dermatitis, and recurrent cellulitis. A causalgia-like state of the involved limb may also be present. It is best treated by a conservative regimen. The patient must realize that the disease is never cured, only controlled. This philosophy must prevail until the day that one can replace the vein deprived of its competent valves by disease with venous grafts having competent valves.

The regimen which we recommend consists of rest, elevation, and elastic support. Open ulcers, if not grossly infected, are best treated by Unna Paste Boots. These are changed weekly at first and, as healing progresses, at longer intervals up to one month. Cellulitis should be treated by appropriate antibiotics. Edema should be controlled by mechanical means; in stubborn cases, systemic diuretics may be helpful. Stasis dermatitis often responds to topical steroids. Systemic steroids should be reserved for extensive cases only. Causalgia, though seen infrequently, is a distressing manifestation and requires sympathectomy for cure. Economically, it is unsound to excise and graft all stasis ulcers. Furthermore, there is little evidence that grafts are superior to the epithelium that forms over the ulcer by centripetal regeneration. Ligation and stripping of secondary varicosities and subfascial ligation of the perforating veins will lessen the chances of recurrence of ulceration.

The third major complication is phlegmasia cerulea dolens. Fortunately, it is infrequent. It is caused by extensive thrombosis of the major venous channels of the limb, often extending up to the renal veins and leading to venous insufficiency. Major tissue loss is inevitable unless thrombectomy is performed promptly.

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*ch bidCAP contains Tetrex (tetracycline phosphate complex equivalent to 500 mg. tetracycline HCl activity).

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

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Contraindications: Severe renal impairment or previous hypersensitivit **Warning:** Ulcerative small bowel lesions have occurred with potassium containing thiazide preparations or with enteric-coated potassium salts sup plementally. Stop medication if abdominal pain, distension, nausea, vomitin or G.I. bleeding occur.

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ALCOHOL INDUCED HYPOGLYCEMIA

is potentially fatal and can be classified as a medical emergency. Dextrostix determination of blood sugar can expedite diagnosis in the emergency room. • The patient generally responds promptly to intravenous glucose, but prolonged severe hypoglycemia can seriously affect the nutritional status of the central nervous system, causing irreparable damage. • This condition is a consequence of heavy drinking without eating over a long period of time. It can occur in normal, well-nourished people, but clinically it is found as a repetitive phenomenon in "binge" drinkers who do not have overt signs of liver damage but, on testing, show reduced effectiveness of their carbohydrate regulating mechanisms. • The metabolism of high concentrations of alcohol rapidly depletes the liver of its glycogen and impairs glycogenesis and gluconeogenesis, resulting in a profound hypoglycemia.

LEON W. BERUBE, MD

Hypoglycemia as a sequela of alcohol ingestion is a potentially fatal condition which, until recently, has received little attention in medical literature. Since many students as well as practitioners may not be familiar with it, a discussion of this entity appears worthwhile.

Physicians must consider a diagnosis of alcohol induced hypoglycemia in the unconscious or comatose patient. Typically, the patient is brought to the hospital emergency room in a stuporous or insensible state. Frequently he is having or has had generalized convulsions. The skin is usually cold and may or may not be wet. The pupils may be constricted or dilated; deep tendon reflexes may be brisk or absent. There is no nuchal rigidity between seizures. Blood pressure, pulse, and respiratory findings are inconsistent. Lack of a history or failure to detect the odor of alcohol on the patient's breath may make diagnosis difficult. Grand mal epilepsy, post-epileptic states, acute alcoholism, hepatic coma, insulinoma, hypertensive encephalopathy, strychnine poisoning, cerebral embolus, internal head injury, and intracerebral disease have all been considered as the probable diagnosis after initial examination of the patient.

The blood sugar determination is the key diagnostic aid. Often blood sugar will be lower than 15mg%. Intravenous glucose usually brings immediate gratifying and dramatic results.

Since so many people drink often to excess, why is this condition not commonplace? Why does not each of us see 10 or 15 cases every New Years Day? Why is it that since 1941, when Harvey and Brown described six cases of hypoglycemia after alcohol ingestion, fewer than 100 such cases have been reported?[1] It is safe to say that many cases go unrecognized and that many a DOA is signed out with an inaccurate diagnosis.

To better understand the phenomenon of hypoglycemia, it is helpful to know the manner in which alcohol is metabolized. Although all the steps and possible side reactions of alcohol metabolism are not yet understood, it is generally agreed that alcohol (ethanol) is first oxidized to acetaldehyde. This process takes place mainly in the liver through the action of alcohol dehydrogenase.[2] This enzyme has a molecular weight of 84,000. It contains two atoms of zinc and two molecules of nicotinamide adenine dinucleotide (NAD).* In the oxidation of alcohol to acetaldehyde, NAD is reduced, becoming NADH. The equilibrium point for this reaction would result in metabolism of little alcohol if it were not for

*This substance was formerly known as diphosphopyridine nucleotide (DPN).

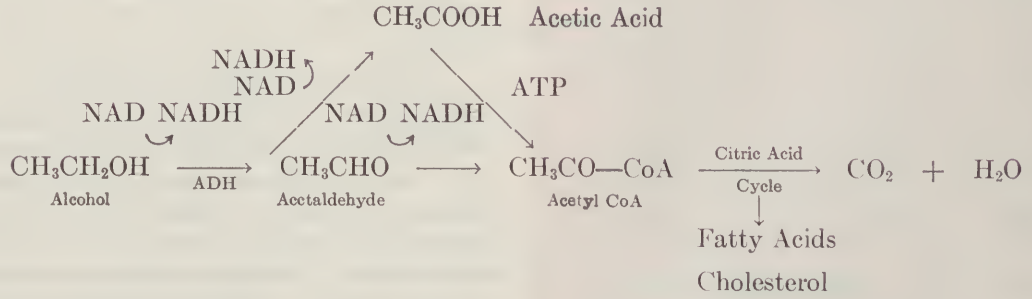
the fact that acetaldehyde and NADH do not accumulate.

Acetaldehyde is rapidly metabolized in the liver by acetaldehyde dehydrogenase. Under the usual physiologic conditions it is transformed to Acetyl CoA and possibly to acetic acid, although the latter reaction is questioned by some investigators.[2]

The NADH is reoxidized to NAD through the flavo protein-cytochrome system in the hepatic cells. The NADH in the cytoplasm of the hepatic cell is oxidized by reacting with the cells mitochondria. When large amounts of hydrogen must be handled, other hydrogen acceptors are used. Pyruvate will then be reduced to lactate and acetoacetate reduced to β-hydroxybutyrate.[3] Fatty acid formation from Acetyl CoA also requires hydrogen, which can be supplied by NADH. The reoxidation of NADH is a complex affair and imperfectly understood. It may well be the rate limiting factor in alcohol metabolism.

Acetyl CoA is oxidized via the citric acid cycle to carbon dioxide and water. Acetyl CoA, an important intermediary in alcohol metabolism, is used in the synthesis of fatty acids and cholesterol by the body.

Thus the generally accepted steps in alcohol metabolism might be shown in simplified form as follows:



Disulfiram (Antabuse) has the oxidation of acetaldehyde as its site of action in this metabolic process. Although disulfiram does not completely stop the oxidation of acetaldehyde, higher blood levels of acetaldehyde must be present. The effect of drinking on patients taking this drug is due to these elevated blood acetaldehyde levels.

Hypoglycemia can ensue from inordinate loss of glucose from the body or from inadequate production of glucose. There are many known causes of hypoglycemia: 1) insulin overactivity, 2) excessive tissue utilization, 3) increased metabolism by tumor or bacteria, 4) renal tubular poisons causing glucosuria, 5) starvation, 6) hepatic toxins, 7) hepatic disease, 8) hepatic enzyme defects, or 9) inadequate supplies of glucose precursors.[4] What is the role of alcohol in the production of hypoglycemia?

It was hypothesized that alcohol could stimulate insulin secretion and thereby lower blood sugar. Freinkel and coworkers[1] measured plasma insulin levels and found no increase after ethanol ingestion. In one patient, seen at the time of admission with a blood sugar of 6mg%, they found an increase in plasma insulin after dextrose infusion.

Glucosuria has not been found in patients with alcoholic hypoglycemia.

Increased tissue utilization of glucose has also been considered as a cause of hypoglycemia. Available evidence indicates that there is no increased utilization after ethanol ingestion. Freinkel et al[1] found alcoholic hypoglycemia associated with rising levels of free fatty acids.

Can ethanol induced hypoglycemia then be due to either or both inadequate carbohydrate ingestion and inadequate endogenous glucose production? It is known that prolonged fasting for several days will produce only modest reductions of blood sugar. Clinical experience has also made clear that the alcoholic who eats does not become hypoglycemic. Investigators have starved patients known to have had ethanol induced hypoglycemia for various intervals. Short fasts, 12-24 hours, did not result in hypoglycemia with the amount of alcohol given.[5] Longer fasts, 44-72 hours caused alcoholic hypoglycemia shortly after alcohol ingestion.[1, 5] However, if these patients fasted but were not given alcohol, they would respond with

a prompt rise in blood glucose following 1mg of glucagon,* suggesting that a fast of three days duration did not totally deplete the liver of the glycogen that was readily available for conversion to glucose.

Field and coworkers[5] starved a patient with known alcoholic hypoglycemia for 68 hours, then gave him 40cc of alcohol. His blood sugar dropped in three hours to 35mg%, and 1mg of glucagon had no effect in raising his blood sugar.[5] This would indicate that ethanol induced hypoglycemia follows removal of all available glycogen from the liver cells. This observation concurs with the findings of Neame and Joubert.[6] In 1960 they performed liver biopsies at the time of admission and before treatment on three patients with alcohol induced hypoglycemia. They found no glycogen in the hepatic cells. Ninety minutes after the intravenous administration of dextrose, one patient had small amounts of hepatic glycogen present.

Why does alcohol rapidly deplete hepatic glycogen, especially if there has been antecedent fasting? Although the last word on this mechanism has not yet been written, a study of the literature suggests the following explanation. The oxidation of large quantities of alcohol results in large amounts of reduced NAD or NADH. Ordinarily the NADH is oxidized via the cytochrome chain, but whenever the NADH load is great, other metabolites accept hydrogen. With the body trying to metabolize large quantities of alcohol at a maximum rate by reoxidizing the reduced NADH, liver glycogen must be used. Liver glycogen breaks down to pyruvate, supplying energy to the reaction. The pyruvate, in turn, is reduced to lactate, thereby oxidizing the NADH to NAD and permitting more alcohol to be oxidized to acetaldehyde.

Seligson et al[3] measured lactate, pyruvate, β-hydroxybutyrate, and acetoacetate levels in the hepatic vein of man 90 minutes after alcohol infusion. Their work showed a relative decrease in pyruvate and a corresponding increase in lactate; a relative decrease in acetoacetate and an increase in β-hydroxybutyrate following alcohol infusion. These results are compatible with this concept of glycogen utilization and explain why a non-fasting individual with abundant liver glycogen would not be as affected by alcohol as he would after a fast had reduced his store of glycogen. They are also consistent with the observation that small quantities of alcohol, not sufficient to bring into play alternate routes for the reoxidation of NADH, do not reduce liver glycogen or produce hypoglycemia. They support Tennent's[7] observation that food taken with modest amounts of alcohol after a short fast (17 hours) brought about no significant change in blood sugar levels from the group who fasted then ingested the same 122cc of whiskey. They agree also with the findings of Forbes and Duncan,[8] who starved rats for 16 hours and then gave some of them large quantities of alcohol and glucose. All of the rats were then killed and the amount of liver glycogen determined. The liver glycogen was much higher in the alcohol-glucose fed rats than in those killed solely in the fasting state.

Alcoholic hypoglycemia can be profound. Numerous investigators have reported levels below 20mg%.[1,6,9,10] Freinkel et al reported patients with blood sugars of 5 and 6mg% on admission. In the first case to be discussed, the patient had a blood sugar of 13mg% on one admission. It would seem reasonable to propose that the extremely low blood sugar levels found after ethanol ingestion could result only from almost total lack of glucose production. If alcohol actively promotes the removal of glycogen from the liver, a point will be reached when the original predrinking glycogen is gone. Any additional new-formed glycogen must come from food or endogenous sources via gluconeogenesis then glycogenesis. It has been shown that the type of patient to become hypoglycemic is the "binge" drinker who "ties one on," having had little or no food[1,5,6,9,10,]; it can thus be assumed that any new-formed glycogen must come through gluconeogenesis. Glycogen synthesis may or may not be affected by alcohol. If gluconeogenesis does not proceed at a sufficiently rapid rate, blood sugar and liver glycogen levels will not return to normal for a considerable length of time, even in the absence of continued drinking. If alcohol interferes with gluconeogenesis, then prolonged drinking without food could result in profound

*Glucagon, a pancreatic hormone with an epinephrine-like action, produces rapid hepatic glycogenolysis and elevation in blood sugar. It activates the enzyme phosphorylase which converts glycogen to glucose-1-phosphate.

hypoglycemia even if alcohol has no effect on glycogen synthesis per se.

It is extremely difficult to show in humans whether alcohol interferes with glycogen synthesis. Field and coworkers[5] showed that fructose given during ethanol induced hypoglycemia resulted in higher blood sugar levels than when given without ethanol. Glucagon given one hour later, however, did not cause as great an increase in blood sugar in those patients who had previously had alcohol as it did in those who had none.[5] This study shows that the conversion of fructose to glucose is not affected by alcohol and implies that the synthesis of glycogen is impaired by alcohol.

Since it is not possible from this study to determine the rate of glycogen formation and breakdown, one could wonder whether the higher blood sugar levels in the alcoholic group might be due to increased glycogen synthesis and subsequent breakdown. Field's experimental work on rat and rabbit livers tends to support his conclusions that alcohol does in fact interfere with glycogen synthesis. In one experiment he perfused isolated rat livers with ethanol, then added fructose to the perfusate. An increase in glucose concentration in the media was noted in both the ethanol perfused livers and the controls, but the glycogen content of the ethanol perfused livers was much less than in the controls. The conversion of fructose to glucose was not influenced by ethanol at concentrations of 0.41%, indicating that the inhibitory effect of ethanol in glycogen synthesis occurs after glucose-6-phosphatase is formed. In a second experiment, he found that liver slices from ethanol treated rabbits metabolized less radioactive glucose into glycogen during a 90-minute incubation period than did liver slices from controls.[5]

How does alcohol interfere with gluconeogenesis to produce the extremely low values of blood sugar encountered in alcoholic hypoglycemia? Direct experimental evidence on humans on the site of alcohol inhibition of gluconeogenesis is not available. Field and coworkers[5] perfused isolated rat livers and found amino acid production to be essentially the same in both controls and ethanol perfused livers. Urea production, however, was substantially decreased in the ethanol perfused group, suggesting the point of interference in gluconeogensis occurs in the deamination of the amino acids, and not before their formation.

Only a small percentage of heavy drinkers become hypoglycemic, but most of those that do have a history of repeated episodes. Several explanations have been suggested. Brown and Harvey thought that hypoglycemia was due to a contaminant in the alcoholic mixture their patients drank, not in the alcohol itself, giving rise to the term "smoke poisoning."[11] As more case reports were published, it became apparent that there was no contaminant: ethyl alcohol itself was the hepatotoxic substance. Neame and Joubert,[6] among the first to reach this conclusion, thought that a poor diet over a long period was the essential factor that predisposed one to hypoglycemia after alcohol ingestion. However, there have been cases of hypoglycemia in children who accidentally drank alcohol who had neither been chronic drinkers nor been on an inadequate diet.[12,13]

Chronic liver disease was thought to be necessary to development of hypoglycemia. Neame and Joubert[6] performed liver biopsies on 17 patients who developed alcoholic hypoglycemia and found evidence of cirrhosis in only three. The remaining 14 had normal hepatic architecture. Hed[14] performed biopsies in 12 cases and found some degree of fatty liver in 11, but none had cirrhosis. Other investigators[1,10] also have found no evidence of chronic liver disease in their patients.

The possibility of an underlying defect in carbohydrate metabolism as the necessary factor in alcoholic hypoglycemia has been studied. Freinkel[1] admitted nine patients with this condition during a 21-month period. After the acute episode was over, these patients were subjected to various "loads" to test how they handled exogenous glucose and utilized endogenous glucose. Responses to glucose tolerance tests were equally divided among normal and diabetic type responses. Response to intravenous insulin was at a maximum somewhat later (30 to 60 min.) than in normal patients (20 to 30 min.) and somewhat more pronounced with a blood sugar one-third of pretest value as compared to one-half in normal patients. Maximal response to IV tolbutamide was generally delayed to 60 minutes rather than a normal 30 minutes, even in those patients who had a normal glucose tolerance curve. They concluded that patients developing clinical alcoholic

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Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

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hypoglycemia did not handle test loads as well as a normal group, even though gross abnormalities in maintaining glucose balance were not found.

The search for the cause or causes of alcoholic hypoglycemia is not over. It has recently been shown that acute sublethal alcohol intoxication produced a substantial increase in urinary excretion of epinephrine and levarterenol in dogs[15] and that an intravenous infusion of alcohol caused reduction of serotonin and norepinephrine in the rabbit's brain stem.[16] The significance of these effects in producing hypoglycemia is a current area of investigation.

CASE REPORTS

Case 1. The patient was a 51-year-old Negro man with a history of alcoholism of at least 15 years duration. He had not been gainfully employed for the past 10 years. He was divorced.

He was 62″ tall and weighed 110 lbs, much shorter and lighter than his brothers. His sisters are tall and thin. They are heavy drinkers, but there is no available history of their having alcoholic hypoglycemic episodes.

Between January, 1964, and April, 1965, the patient was admitted to the local hospital eight times, in various degrees of unconsciousness. He was hospitalized twice in Johns Hopkins Hospital, with one admission of six weeks duration. He was extensively studied at Johns Hopkins. His liver function was normal, and a needle biopsy of his liver showed only mild fatty changes. He had two glucose tolerance tests, one with an essentially normal response, the second with a diabetic type response. He had a prompt hypoglycemic reaction to intravenously administered alcohol, no response to glucagon, but a prompt response to intravenous dextrose. Additional findings were chronic renal disease, inactive pulmonary tuberculosis, and anemia.

Almost all of his admissions occurred between 10 AM and noon, because his cronies would miss seeing him in the neighborhood. As a rule he would have generalized seizures either before or at the time of admission. He usually responded well to intravenous dextrose, becoming alert and symptom-free in two to four hours. On one admission, his blood sugar was 22mg% and blood alcohol level, only 0.05%. This is consistent with the finding that there is no correlation between the blood alcohol and the blood sugar levels.[14] His lowest blood sugar on admission was 13mg%.

Matters took a turn for the worse in December, 1964. On December 16, he was seen in the emergency room with a blood sugar less than 40mg%. He responded well to IV dextrose and was allowed to return home with friends. But he was returned to the hospital at 3 PM, comatose and in convulsions, which continued for 12 hours. His blood sugar on admission was 110mg%; at 4:30, 150mg%; at 9:55, 250mg%. He had neither food nor IV fluids until 10:20 PM. He was mentally depressed on December 17. Not until the next day did he appear alert; he then complained of weakness in his right hand.

His final admission was April 20, 1965. Blood sugar was 49mg%. He responded promptly to IV dextrose, but his mind was not clear. Five hours after admission he suddenly developed generalized seizures, became unconscious, and died 30 minutes later. We were unable to obtain an autopsy.

This case illustrates many of the observations noted by other investigators. In some ways it is a composite of their findings.

This case has its bittersweet side. Throughout Lent, March 3 to April 18, the patient gave up alcohol as a measure of self-denial. He started drinking heavily after attending midnight mass on Easter Sunday. He was found at home, unconscious, on Tuesday, April 20. It might be that his abstinence from alcohol during Lent had permitted his central nervous system to lose its tolerance to alcohol, contributing to the effect of his heavy drinking Easter Sunday and Monday.

Case 2. The patient, a 74-year-old Negro man, was brought to the emergency room at 8 AM on April 18,1965. It was presumed that he had a cerebrovascular accident. He was in a deep coma. An airway was positioned with no response. A Dextrostix blood sugar determination showed a blood sugar of less than 40mg%, found later to be 35mg%. He responded promptly to IV dextrose. The airway was removed by 9:30 AM, and half an hour later, he was talking and moving about. We learned that the patient had not eaten while drinking his Old Crow. He was told in not uncertain terms that that was a "bad bird" for him, and he has not been in trouble since.

These cases are mentioned to make two points and one conjecture. First, alcohol induced hypoglycemia is probably more common than is generally considered. Second, prolonged hypoglycemia can produce serious, irreversible changes in the central nervous system. The CNS depends on blood glucose for its nutrition. Other metabolites in the blood cannot replace the need for glucose, even for relatively short periods.

One must remember that the biochemical and physiologic changes that take place in the body are not isolated occurrences in time and space but go on simultaneously in the various organs and blood stream. Glycogen, a source of readily available high energy glucose is contained in the muscles. This glycogen is not affected by alcohol or fasting, but during convulsions, considerable quantities of it must be used in producing lactate. Since the glycogen-lactate reaction is reversible, one can conjecture that the convulsive seizures seen in alcoholic hypoglycemia are an attempt by the body to convert lactate to glycogen and glucose in order to provide nourishment for the CNS.

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MEDICAL HYPNOSIS

JACOB H. CONN, MD

Whether treatment by hypnosis is here to stay or whether it will be disparaged, ridiculed, and again disappear from the medical scene will depend upon its use in carefully selected cases by informed practitioners. The history of hypnosis repeatedly has demonstrated that hypnosis has been destroyed not by the excessive criticism of its skeptical opponents but by the extravagant claims of its overly enthusiastic proponents. The members of this Academy and physicians belonging to other practitioner groups are the future hope of medical hypnosis. I have spoken at national meetings to doctors from all parts of the country who have become interested in hypnosis. To them, the practice of hypnosis represents a way of getting closer to their patients and helps them to feel more like doctors practicing an art and less like technicians carrying out routine studies.[11]

The use of hypnosis is a natural consequence of what the doctor is doing in everyday practice.[14] The physician makes direct and indirect suggestions to every patient. When he tells a patient that a laboratory test is non-contributory or that the physical findings are negative, he is in effect suggesting to the patient, "You can stop worrying." When an injection is given, the doctor is suggesting, "You are being cured." Thus, the injection of a saline placebo reportedly has been effective in significantly reducing the systolic pressure over a period of 59 weeks (and the diastolic pressure for 123 weeks) in a series of patients with essential hypertension, while an oral placebo yielded no such response.[19] The writing of a prescription suggests to the patient that his condition can be helped without probing into psychological issues and that he can ignore or forget (repress) the underlying conflicts.[22]

Medical hypnosis organizes these suggestive influences which are based upon the sick person's need for someone to relieve his distress and, therefore, to endow his physician with the power to help and to heal. Hypnosis is not a state of mind but the end result of various psychologic processes. The ideal patient is intelligent and cooperative. The best hypnotist in the world cannot walk up to a stranger in a hotel lobby, announce, "I am going to hypnotize you," and succeed. The patient must be willing and able to concentrate on what is being said and to believe that whatever the doctor says will happen can and does happen. In brief, if the patient will look where you tell him to look and will pay attention only to what you say

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to him; if he will follow your instructions and let things happen and implicitly believe that you have the power to predict what will occur, then he can be hypnotized effectively.[4-6]

The doctor, in turn, must be convinced of his ability to succeed. He must learn to overcome the feeling of self-consciousness during the phase of induction when he is instructing the patient how to act and what to expect.

Hypnosis has been used to relieve intractable pain in patients with terminal cancer.[2] The relief of pain may last up to several hours or longer, and the patient is taught how to hypnotize himself whenever he requires relief from pain. One comprehensive report concludes that the use of hypnosis substantially reduces the amount of narcotics and helps to keep the terminal cancer patient comfortable and free from anxiety.[3]

I am convinced that excruciating pain—pain that is refractory to narcotics and resistant to all types of analgesic drugs—always includes a major psychologic component. Last year I was asked to see a woman who accidentally had severed the radial and ulnar nerve and most of the tendons of one hand. Her pain was excruciating and did not respond to any type of medication. I hypnotized her, and in about five minutes she reported that her pain was 90% better! Now, a moment's serious reflection is enough to conclude that merely staring and concentrating upon a spot could not have produced this effect unless the patient had an intense conscious need and an unconscious wish to develop this type of interpersonal relationship, which is characterized by selective inattention and passive detachment.

This need on the part of the patient is illustrated by Crasilneck's observation that the sicker the severely burned patient is the better he is as a hypnotic subject. The burned patient not only obtains relief from pain but can be made to exercise the burned limb and can be influenced to eat larger quantities of required foods so that healing occurs more rapidly.[18]

The value of hypnosis in reducing pain and anxiety has been reported in cases of urethral and rectal instrumentation, minor surgery, changing of dressings, and the manipulation of painful joints.[23] In the accident room, hypnosis has been found to be useful when a patient has eaten recently and a general anesthetic cannot be given immediately. Many reports have cited the value of hypnosis in gynecology and obstetrics. The pain of causalgia, phantom limb, and post-herpetic neuralgia has been relieved in selected cases. It cannot be emphasized too often that if the patient is to be helped he must be cooperative and be able to live without his symptoms, which may be of use to him as a neurotic defense and represent a secondary gain. The patient may have become the center of attention, may need to punish himself, or is being supported financially and is receiving the sympathy which he requires and now demands as his right. He may thus be unwilling, hence unable, to surrender his symptoms even under hypnosis.[10, 14, 15]

Chronic skin disorders have been alleviated; warts respond well to hypnotic treatment. In selected cases, persistent hiccups, migraine, thumbsucking, enuresis, nail biting, excessive cigarette smoking, alcoholism, and obesity[24] can be treated effectively. Frigidity, dyspareunia, premature ejaculation, and impotence usually are associated with severe personality disturbances and therefore require psychotherapy as well as hypnotherapy.[20] I have reported the beneficial effects of the hypnotic treatment of war neuroses, sex offenders, and severe hysterical depressions.[6-8, 12]

The treatment of stuttering is not as easy or as successful as some reports would suggest. The lifelong stutterer has developed severe neurotic defenses and is resistant to hypnotic treatment. The onset of stammering in adolescence is usually an hysterical disorder which is amenable to hypnotherapy. There are the amnesias of acute onset and fugue states for which hypnosis is a specific form of treatment.

The recall, under hypnosis, of a single traumatic event or series of traumatic experiences (which often are spurious) is not invariably associated with cure. Therefore, it is wrong in principle and misleading in practice to inform the patient directly or indirectly that he will recover as soon as he can recall certain "buried" memories. What usually happens is that the patient feels compelled to fabricate traumatic events in order to please the hypnotist. Hull has shown that patients fabricate more readily under hypnosis than in the waking state.[20] Each hypnotist obtains those psychological contents, which he indicated to his patient as being the ones that interest him.

The practitioner must remember that the value

of emotional release (abreaction) lies not in itself but in the fact that the patient is ready (set), able (mature enough), and willing (unconsciously wishes) to get well and to stay well (that is, he can maintain realistic goals). Only then can the patient endow the therapist of his choice (the transference object) with the power to cure him.

Hypnosis, like penicillin, should be used discriminately and always with the full consent of the patient.

The general practitioner should always begin by using waking suggestion. Certain patients are more suggestible when fully awake. The doctor who tells a patient: "You are beginning to look better. You are one of my best patients, and I expect you to improve even more during the next two weeks," is bringing new life to his patient. A recent study of glaucomatous patients[1] demonstrated that intraocular tension was reduced more effectively when the doctor directly told the patient, in a sincere manner, that the headaches would disappear and that the eye condition had improved than when suggestions were given while the patient was under hypnosis or posthypnotically.

Some patients are most suggestible when asleep; others respond best to suggestions in the light stage of hypnosis. A patient may develop a somnambulistic state and still may not respond to suggestion if he is not properly motivated. Dr. Wolberg tells of a doctor who asked to be hypnotized to prepare himself better for the New York State Board examination. He was an excellent subject and all went well. On the day of the examination he called Dr. Wolberg and sheepishly confessed that he had not taken the examinations because he had overslept. His father had insisted that the patient take the examinations in New York, but the young man had a sweetheart in another state and preferred to take his boards in that state. He had solved the problem by oversleeping, after having consented to take them in New York to please his father.

Many patients are passive and remain silent as soon as they develop the specific interpersonal relationship which is the trance state. These individuals should be told, "Enjoy being relaxed. You have nothing on your mind. That is good. Don't say anything until it comes to you naturally and without effort. What you say is not as important as how you act in keeping with your natural, real feelings. You can say nothing and get well, if that is what you want to do." In this manner the patient is free to find his own way of expressing himself while in the trance state.[10]

One of the recurrent problems is the patient who insists that he has not been asleep; hence he has not been hypnotized. Hypnosis is not sleep, it is "imitation" sleep. I tell my patient that hypnosis is not sleep and that if he wants to sleep to do it at home. "You came here," I say, "not to sleep but to learn how to relax and how to live more effectively, fully, and without your present neurotic complaints." The patient in the hypnotic trance is not passive; he is an active agent who uses the doctor as the means of restoring the patient's feeling of mastery and control.[9]

The patient will not do anything contrary to his moral code if it is directly suggested; but if his perceptions and conceptions are altered, he may steal or attack any person who is pointed out as being a danger to himself or to his loved ones.[11]

The patient awakens when he is told to do so with very few exceptions. It takes much more skill to induce the trance state than to arouse the patient, who, if left alone, will "sleep it off." Failure to awaken (dehypnotize) usually occurs either because the patient is hostile to the hypnotist and wants to remain longer in the trance so as to "even things up" or because he enjoys being in the relaxed trance state and does not care, for the time being, to return to his troubled life situation. The effective handling of such resistance and hostility should be part of the training of any hypnotherapist.[12]

Neither amnesia nor the "deep state of hypnosis" is necessary for therapeutic success, since in many cases "cures" can be achieved with suggestion in the light stages of hypnosis. It is not necessary for the patient to talk while in the trance state. Excellent results can be obtained without probing for psychological contents. The hypnotist only sets the stage; it is the patient who induces the trance by doing what is expected of him.

In 1941, a young married woman whom I had interviewed several times asked: "Why don't you do something else besides talking to me? Why don't you hypnotize me?" I was willing to do so, but as I had never hypnotized anyone previously, I hesitated until the patient added the additional stimulus which I needed by saying, "I know that you can hypnotize me because my husband can do

it, and he is not even a doctor." As my professional self-esteem was at stake, I held up my hand with an assumed self-assurance, and before I had a chance to speak, the patient entered into the trance state; she had hypnotized herself.[15] This experience taught me humility. All I had done was to set the stage; it was the patient who had satisfied a particular psychological need by establishing a specific type of interpersonal relatedness which was characterized by passive compliance and selective attention. Thus, at the very beginning of my interest in hypnosis, I learned that anyone, even someone who was ignorant of the theoretical and technical implications of hypnosis, can hypnotize a patient.

Even when the patient is skeptical and says that he has no faith in hypnosis, it is how he behaves rather than what he says which indicates the degree of his unconscious need for a regressive, compliant relationship.

The psychodynamics involved in the hypnotic relationship can be summarized as a need to dominate or to be dominated, a conviction on the part of the subject that he will fail in the task of hypnosis, a fear of losing his will power, a need for dependency, expiation, or the feeling of guilt and a terror of intimate interpersonal relations. To some patients, hypnosis may mean death, a homosexual or heterosexual relationship, or a rebirth fantasy.[9]

The hypnotist also must know himself. He must not derive too much vicarious satisfaction or power from the treatment of the patient in the trance state. He must be aware of the dangers of becoming involved in the patient's paranoid projections, of arousing repressed conflicts which may overwhelm the patient, of becoming the object of the patient's sexual fantasies, or of removing symptoms in disturbed, unstable individuals who require their symptoms as defensive maneuvers.

The dangers of hypnosis are those which accompany every psychotherapeutic relationship. Anyone who hypnotizes a prepsychotic patient without knowing what he is getting into is like the fool who ventures where angels fear to tread. *Psychiatric training is an absolute prerequisite for diagnosis as well as for intensive hypnotherapy.*[13] The average practitioner should confine his hypnotic efforts to the preparation of the patient for surgical procedures, and the alleviation of pain (analgesia and anesthesia) and postoperative comfort.

Every medical procedure includes the same fundamental ingredient: the personal worth of the doctor. Hypnosis is nothing more than suggestive influence of the doctor upon whom the patient depends for both care and emotional support, presented in a specific interpersonal setting. It is not a panacea for all the ills of mankind. If it is used discriminately for those who can endure living without their neurotic defenses, then in these *carefully selected* cases hypnosis can help to remove the functional overlay of organic disease, to relieve pain, to alleviate anxiety, and to facilitate the recall of significant traumatic events.

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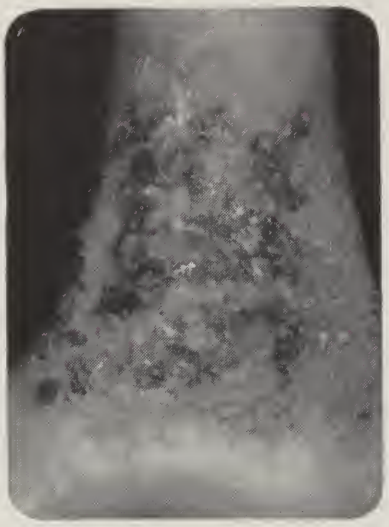
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Suggestions for mature people approaching retirement

W. GRAFTON HERSPERGER, MD

It is important for men to plan for their retirement or bonus years—more people are living longer. At the beginning of the Christian era, the average life span was only a little more than 22 years. Records in England and Wales during the 1850-1860 decade show that the average length of life in those countries was approximately 40 years. In 1900, the average American could expect to live 47 years. In 1960, in the United States, the average life expectancy for men was 69 years and for women 73 years. An article in January, 1965, indicated that the age for women has advanced to 75 years. During the past several decades, the life expectancy for women has been lengthened because of a significant reduction in deaths associated with childbirth.

The exact reason why women live longer than men is not entirely clear. Some have suggested that nature places a higher value on the female of the species; others have suggested that women have a more rugged and durable constitution. We know that the high level of the female hormone is significant in reducing the incidence of coronary artery heart disease during the childbearing period. There are exceptions, however, as evidenced by the occurrence recently, in Baltimore, of coronary thrombosis in a woman 22 years of age. It is generally believed that women do not experience as much stress and that, for the most part, they do not work as hard or as intensively as men. In the past it was thought that women worried more than men, but recent observations indicate that husbands are worrying equally as much as their wives.

At the present rate of increase, it appears that the average life span will have reached 80 years in 1980. The life expectancy increases with advance in age; when one has attained the age of 65 years, there is every reason to believe that he will live to be almost 80 years of age. At age 85, an average of 90 years may be anticipated.

In many undeveloped areas of the world where modern methods of sanitation, health facilities, and disease control are essentially unknown, the average life span is not much greater than it was during the early Christian era. When the limited life expectancy in such areas is compared with the present figures for longer life in North America, it is interpreted as evidence of the part science is playing, and will continue to play, in prolonging life.[1]

How long then can a person live with the best possible heredity, the most healthful living conditions, the ultimate in medical attention, and, in addition, good luck? In the fifth chapter of Genesis, one reads that Methuselah lived 969 years and that Lamech lived 777 years; and in the ninth chapter of Genesis, we find that Noah is said to have lived 950 years. Most interpreters explain the high figures given for these ages as a manifestation of the enthusiasm of the chronicler for his ancestors and believe that the writing is basically symbolic. Methuselah was 187 years old when his son, Lamech, was born; Lamech

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was 182 years old when his son, Noah, was born. Noah was 600 at the time of the flood. If one adds 187, 182, and 600, the total is 969 years, which is the age at which Methuselah died. One well might ask, "Did Methuselah drown at the time of the flood and die prematurely?"

The Ninetieth Psalm tells us that we may expect to live three score years and ten and, by reason of strength, four score years. The average life expectancy in the United States has passed the three score years and ten mark and is now on the way to four score years, which will probably be attained in approximately 1980. The sixth chapter of Genesis states, "Man's days shall be an hundred and twenty years," this concept having been obtained from the Egyptians by the Jewish people. It is not at all unusual, when one orthodox Jew takes leave from another, to hear him say, "I will see you in Jerusalem and may you live to be an hundred and twenty years." A doctor here in Baltimore who has many orthodox Jews as patients reports that when they leave his office they will frequently say to him, "May you live to be an hundred and twenty years."

An Eighteenth Century French anatomist, Georges Buffon, observed that the average duration of life of an animal was approximately five or six times the period required for the maturing of his bones.[1] He observed that the average dog's bones matured in two to three years and that the dog lived to an average of between 12 and 18 years. One of my anatomy professors reports that chimpanzee bones mature in five to six years and that, in captivity, it is not at all unusual for a chimpanzee to live to be 30 to 35 years in age. Man's skeleton matures in about 25 years. If we multiply 25 by 5 or 6, the product is 125 to 150 years. To be scientifically honest, however, I must say that my former anatomy professor reports that in some rodents a few of their bones do not mature until the animal has reached old age. These facts, then, with respect to the Buffon formula are reported simply as a matter of interest and speculation.

How close has anyone ever come to attaining such an age? There have been reports from time to time of a person's having lived to a fabulous age; but these reports have not been adequately documented. The oldest Civil War veteran lived to be 117 years old, and more than 40 others lived more than 100 years. There are now several thousand centenarians in the United States. The University of Kharkov, in Russia, has several thousand centenarians under observation and study, and numerous other centers on the Continent are making similar observations.[1]

Recurring reports during the past score or more years have described the Hunzas as people of extraordinary good health and exceptional longevity. It is said not to be unusual for the men to attain ages of 120 to 140 years. Hunza is an isolated country about the size of New Jersey, situated high in the Himalaya Mountains, just north of the Pakistan border and approximately 15 miles from Russia. From 1948 to 1951, a vertebrate paleontologist, now on the staff of the Chicago Natural History Museum, lived among and worked with the Hunzas. In addition to showing them how they could make the best use of their natural resources, he established a medical dispensary, to which the people made 5,680 visits for treatment during the three-year period. There were few with diseases common to civilization. Nutritional disorders, such as scurvy and rickets, were common, as were marked dental caries, skin infections, and epidemics of severe dysentery. Many of the Hunzas had malaria and intestinal worms, and 5% of the population had trachoma. Direct questioning of the teenage boys revealed that in many instances one or two members of their families had died relatively young and that there were no written records to document ages of the Hunzas. The author's prolonged period of living among the Hunzas led him to contradict the impressions reported by other travelers based, he believes, on too brief a period of observation. The Hunzas do develop certain types of disease, and the author concluded their average life expectancy is not significantly greater than that in other parts of Asia.[2]

The answer, then, as to how long a person can live cannot be given at the present time. However, the conquering of one disease after another and the attacking of the congenital disorders and the deteriorations have led some students to predict that within the next 50 years, the average life expectancy of persons having the benefits of scientific investigation and treatment will exceed 100 years. It would appear that the most difficult hurdle to be taken is that of finding a way to properly balance the human body chemistry and prevent the deposition of "rust in the pipes"—

atheromatous plaques—elevated areas in the lining of arteries that appear to begin as deposits of fat molecules and cholesterol.

Gerontology, a word derived from the Greek words for old man and treatise, is the science or the study of aging. It includes: 1) aging of the individual as a unit, 2) biologic changes affecting the different tissues, 3) sociologic aspects of aging. The discussion which follows will concern itself primarily with the first and, to a lesser extent, with the third.

Geriatrics, derived from the Greek words for old age and "relating to the physician," is that department of medicine concerned with problems peculiar to old age and aging. Geriatrics is not a specialty in the usual sense of the word because the services of many different types of physicians are required. The general health and illnesses of older people require services of the general practitioner, the internist, the orthopedist, the dermatologist, the general surgeon, and so on. It is preferable to speak not of geriatrics but of geriatric medicine. Geriatric medicine is concerned not only with the sick but also with those who are well; not only with persons 65 years and more but especially with those in the 40-60 age group. It is frequently possible during this period to detect physical, psychological, and emotional deviations from the normal and take steps to correct, or at least modify, these deviations before they have reached an advanced stage and thus help people have better health when they reach the mature and older years.

Persons in this middle age group are encouraged to develop intellectually, sometimes spiritually, to maintain social contacts, to participate in some community effort, and to try to develop hobbies. It is best that the hobby be an active type hobby, one in which the individual takes the leading role and in which he creates something, such that an end product is the result. Several months ago, a letter carrier was asked if he had made any plans for retirement. He promptly reported that he had; that during recent years he had been doing the painting and wallpapering in his own home and for several others in his neighborhood. He was confident that upon retirement from the postal department, he would find plenty of work not only to keep him busy but also to provide an income to supplement the pension he would receive. Another man, who is already retired, has had carpentry and woodwork as his hobby through the years. When he observed that there were many boys in his neighborhood who seemed to have nothing to do, he used a portion of his basement to set up a school in carpentry and cabinetmaking and provided the tools so that boys could come and learn a new skill and spend at least a portion of the time off of the streets of the community. This man has realized much happiness and satisfaction from this work, being confident that he has done much to reduce the juvenile delinquency in the area where he lives.

At the Keswick (Home for Incurables), in the Occupational Therapy and Arts and Crafts Departments, the concept of creating something so that one will have an end product is emphasized among the patients. The patients paint pictures and trays, weave, sew, knit, work in ceramics and woodwork and leatherwork, and have entered many of their products in a local county fair. The ribbons that they win and the objects that they create are a great source of happiness to them and do much to help them psychologically, in addition to helping to keep their minds and their hands active. On one of my visits an older woman, who was sitting in a wheelchair, said to me, "Doctor, look at this little doll that I have made. These old legs of mine are no good, but my hands are all right, and this little doll is going to make some child happy at Christmastime."

It is better not to confine oneself to passive hobbies such as reading, watching television, playing bridge, or going to the theater. It helps much to see something accomplished and to have an end product. Many people obtain this same satisfaction by visiting the members of their church who are ill, or homes for the handicapped, the blind, the mentally disturbed

Sixty-five is not old. Men are not necessarily "as old as their arteries," as you have heard stated from time to time. Men in their 20's and 30's frequently have tortuous, thickened temporal arteries, and many laymen have thought that this represents serious arterial disease. In reality, the changes do constitute an aging process of the artery, but it is the middle coat of the artery that has undergone degeneration and loss of muscle and elastic tissue. The canal in these arteries does not become obstructed, and such arteries almost never rupture. Contrast this process with the development of the atheromatous plaques, in

arteries such as the coronary arteries of the heart. This is a serious degenerative change in the artery because it is the inner layer of the artery that is affected and its location in the coronary artery is a life-threatening process which may very well lead to coronary thrombosis. The important consideration, then, is not just simply the aging process in the artery but the nature of that aging process and the particular artery in which it takes place. Men are as old as their skin, scalp, cerebral cortex, arteries, bones, and all their other tissues. The calendar is not necessarily a good yardstick, much depends on the individual's attitude and his spirit. The most important item is the way one selects his parents.

Aging includes all of the acquired changes through the years plus the involutional changes common to man. Involutional changes include graying of the hair, loss of hair, loss of teeth, thinning and loss of elasticity of the skin, farsightedness (presbyopia), loss of muscle mass and agility, fragility of the bones, arteriosclerosis, certain types of arthritis, and enlargement of the prostate.

At this point, attention is called to an article in a recent issue of one of the popular magazines. The author of this article indicated that a one-minute rectal examination every six months will enable the doctor to find hard areas in the prostate, indicative that a cancer has developed.[3] This cancer can be removed if the abnormal tissue has not extended beyond the prostate. In the event the latter has occurred, the female hormone can be given in moderately large doses and, in addition, the male gonads removed. The removal of the male gonads eliminates the organ that produces the major portion of the male hormone which tends to promote the further growth of prostatic cancer and the administration of the female hormone tends to cause dissolution of the prostatic cancer wherever it happens to be located. As a result, the life of the individual may be prolonged many years.

The ability to learn continues into advanced years, providing the person has had the capacity to learn during his younger years. The reason that older people do not do well in intelligence tests is thought to be a result of diminished speed rather than of diminished knowledge. Judgment tends to increase with the years if the individual has had good judgment when he was younger. It is surprising how often intelligent men come to the doctor's office greatly upset because of a reduction in the sex urge. This is something that comes to everyone sooner or later and should be accepted with tranquility and one's interests directed into other channels.

The acquired changes include significant injuries, infections involving the lungs, kidneys, and bladder, and the effects of stress and tension. The incidence of cancer of the lung is much greater in persons who smoke, especially those who smoke excessively; and cirrhosis of the liver may develop in those who drink alcohol excessively and do not have a good general diet. At any one time, a person's health may be said to represent the sum of these involutional and acquired changes.

It is impossible to discuss all of the complaints people in their mature and older years present to the doctor. Pain in the chest is a symptom that nearly everyone experiences at one time or another, and we will speak briefly about this. Most people who have pain in the left side of the chest do not have heart disease, although many think they do. Often a member of the family may have had a heart attack, or they know some other person who has. Furthermore, heart disease is being given a lot of publicity in the various news media. There is, too, the fact that the heart is the organ of sudden death. The heart has always been a focus of interest, giving rise to familiar expressions such as warm-hearted, heavy-hearted, heartfelt, faint-hearted, chicken-hearted, loving with all my heart, hard-hearted, heartless, and heart fluttering or trembling. Little wonder that discomfort in the chest gives rise to anxiety. If a person has discomfort in the chest that he suspects might be related to the heart, he should consult his doctor and allow the doctor to make whatever examinations are indicated. If no evidence of heart disease is found, he should have confidence in the information given by the doctor but should report the occurrence of any new symptoms.

If some disorder of the heart is found, the physician should take time to explain to the patient the extent of the abnormality and try to allay his anxiety, thereby helping to reduce the likelihood of early recurrence. The physician should outline a program of management, which includes an effort to reduce stress in whatever way possible. This relates to problems at the individual's place of employment as well as in his home. The total

calorie intake should be such as to maintain the person's weight at normal or slightly below normal for his height and age. This ordinarily requires reduction of both starchy foods and fat.

The relative importance of reducing fat in the diet, especially saturated fat, is not completely settled. Studies are being carried on in various centers in the country, and the answer may be forthcoming within the next few years. For the present, it seems desirable to limit to some extent the foods that are high in saturated fatty acids. A well known cardiologist says, "In our society, the worst form of malnutrition is over-nutrition."

Salt intake should be restricted.

Recent observations appear to indicate that persons who smoke cigarettes, especially those who smoke more than 20 cigarettes a day, have an incidence of coronary thrombosis between two and three times as high as those persons who do not smoke cigarettes. There is reason to believe that if a person discontinues smoking cigarettes, the likelihood of his suffering coronary thrombosis will be essentially the same as if he had never smoked.

Regular exercise within the capabilities of the person is important, approximately one-half hour each day being set aside for this. The amount of exercise taken should be less than that which gives rise to any heart symptoms or to undue fatigue.

All normal people want to live long, but longevity is not the primary object. The quality of the life during the mature and older years is much more important. The additional years should be characterized by the best possible health and economic security, self-reliance, self-sufficiency, maintenance of social contacts, participation in some community activity, and continuance of intellectual pursuits as long as one is able. The best possible health can be maintained by selecting a physician, if one has not already done so, and by allowing him to take a complete history and make a thorough physical examination and do whatever x-rays and other tests that are indicated. Every aspect of one's health—physical and psychological—should be discussed with the physician, and periodic examinations should be made, perhaps once a year. If new symptoms develop in the course of the year, these should be reported promptly to the physician.

Self-sufficiency, economic security, and the making of a contribution to the community could, in most instances, best be accomplished if the person is able to continue his regular occupation. However, the trend seems to be toward setting a younger rather than an older age of retirement, possibly moving toward age 60. A recent study[4] projecting labor availability to the 1970-1975 period and, at the same time, estimating the economy's needs at that time, indicates that the supply will be significantly greater than the demand, and there is every reason to believe that the older worker will be the one primarily affected. The concept of "flexible retirement," whereby a person may retire several years in advance of his compulsory retirement age, has been suggested as a means of reducing the total labor force and making available positions for younger workers as well as for some of the older ones who might wish to work longer than their specified retirement age. It is not generally believed that this will do much in the way of providing work for the older person.

One of my friends retired from the Baltimore Gas and Electric Company two years ago, when he was 55, and has been helping his wife in a post office in Baltimore County. He is also an organist and is frequently asked to play in churches and elsewhere. When he was asked whether he had been as happy during these past two years as when he was working regularly, he said that he was happier and more content, that he was so busy that he could not find time to do many things that he wanted to do. Contrast this with the results of a survey several years ago of a large number of men who were approaching compulsory retirement at age 65 years. Only 10% of those questioned desired to retire. Apparently, for financial and psychological reasons, the majority wished to continue their usual way of life. However, recently, among my patients who have been approaching retirement, at least half report that they are looking forward to it, apparently having made plans for the things they wish to do and believing that they will be able to make the financial adjustments that will be necessary. This is not to say, of course, that many people whose interests have centered solely about their work do not tend to deteriorate more rapidly once they have left it.

It does seem unfortunate that business and industry should not continue to make use of the wisdom and knowledge and experience as well as

the skills of the older workers. Once retired, their opportunities for useful and rewarding employment are limited. It is the loss of society as well as of the individual. I have a patient who is a chemist, age 63, now employed in industry, who has done some teaching in high school and junior college during his career. Two years hence, at the time of his retirement from industry, he hopes to teach chemistry in high school or junior college. Many of the smaller colleges are employing capable teachers who have been retired from the larger universities and find that both their faculties and their students benefit.

Some students of the problem point to the possibilities for employment of older persons in service-type occupations and the need for more effort in the field of social improvement. There are those who suggest that greater employment of older people would increase their buying power, which would increase the gross national product; this, in turn, would provide more employment opportunities. Such an increase in the gross national product could occur only if employment of these older persons constituted a net addition to the total work force. Only time and the economists can supply the answer.

Whenever I have talked with groups of people approaching the retirement age, I have encouraged them to try to find a different type of work to do, full-time or part-time, with pay or voluntary. Most people find such new work serves as a stimulus and a challenge and that it can bring them many years of happiness and satisfaction. The son of one of my patients retired from a position as vice-president of a bank two years ago. During the past 21 months, he has been the director of the Over Sixty Employment Counseling Service. He reports that during this period, 1,100 people over 60 years of age have registered for employment and that more than 400 have been provided positions, either full-time or part-time. The leaders of the larger businesses and industries in the Baltimore area have manifested great interest in this project and have made generous financial contributions toward supporting it, but they have not employed these older people because of the existing policies of compulsory retirement and the pension plans that all of them have. The director of this Employment Counseling Service reports much happiness and contentment in this new work. He is convinced that it is helping him just as much as it is helping those for whom he is able to obtain work.

As one tries to maintain the best possible physical, mental, and emotional health and the greatest degree of security possible, he should cultivate the spiritual, too. As we increase in years, we tend to spend more time contemplating the hereafter, examining our convictions and endeavoring to strengthen our religious faiths. I have observed that many of my older patients read the Bible regularly. I find them reading it early in the morning, before turning to the daily paper with all of the disturbing headlines on both the front and the back pages. It seems to give them a better start for the day. I have also observed that the happiest, most contented older people are those who have succeeded in developing a satisfying religious faith.

Finally, I would say that the person who keeps body and mind active and interested and curious for knowledge, who avoids becoming self-centered, but takes an interest in social and community activity, who finds some type of new work to do, who does not neglect the spiritual, and who makes up his mind to be optimistic, and avoids being irritable with his family and friends has the best chance of enjoying the bonus years. Physical changes do occur in all of us, but sooner or later we discover that with modification of pace and cultivation of a cheerful and healthful state of mind, the reduction in physical vigor can be sufficiently compensated for by a mature philosophy, the product of the experiences and accumulated knowledge and, hopefully, wisdom, as the years come and go. The retirement or bonus years constitute another stage of life and can be happy years toward which many people look forward.

Robert Browning wrote in "Rabbi Ben Ezra":

> Grow old along with me!
> The best is yet to be,
> The last of life, for which the first was made
> Our times are in his hand
> Who saith, "A whole I planned,
> Youth shows but half; trust God: see all, nor be afraid!"

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

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Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result fro secretions penetrating the bronchi and bronchiol In laryngospasm, there are both inspiratory and e piratory stridor and difficulty in inflating the ches in bronchospasm there is an expiratory wheeze, b not as much difficulty in inflation, although som resistance may be felt. Stridor is due to partial complete closure of the vocal cords in spasm and t "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produc *difficulty in ventilation* through the mouth until t patient is deep enough to place an oral airway. A intravenous agent can be given to facilitate the duction of anesthesia.

Difficulties can arise if intubation is performed ventilate the patient. For example, teeth can broken by too vigorous attempts at intubation, the intubation itself may be technically difficult d to secretions obstructing the view of the glottis. T postoperative sequelae of intubation ranges fro mild laryngitis to pneumonia with atelectasis, a are seen far more commonly in patients sufferi from colds than in normal patients.



Successive stages of laryngospasm which produce the c acteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications

The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary:

Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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Dosage: Adults—2 teaspoonfuls; Children 6 to 12 years—1 tsp.; Children 1 to 6 years—½ tsp Administer every four hours. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs Use with caution in patients with hypertension heart disease, diabetes or thyrotoxicosis.

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RAYMOND T. BENACK, MD
Clinical Instructor in Medicine
Georgetown Medical School

Allergy in Private Practice

Allergy can be treated. Without treatment the allergic patient may develop unnecessary complications and possibly die. The physician has a responsibility to prevent complications by instituting an effective therapeutic program to alleviate and control the allergic symptoms.

Early diagnosis is important to effective treatment. Detailed history, physical examination, laboratory studies, x-rays, and skin tests should be used to aid in identifying the responsible stimulant. The physician should then begin therapy promptly, keeping in mind the purpose of the treatment and the possible reactions.

The physician's own experience should determine his selection of the hyposensitive technique. In a two-year study of 32 patients, the author found pyridine alum-precipitated extracts superior to aqueous extracts.

There is a saying, "All that wheezes is not asthma." It can also be said, "All that sneezes is not a cold."

Allergies may present as a cold. The classical ragweed hay fever, characterized by nasal rhinorrhea, nasal congestion, and frequent sneezing, which occurs from mid-August to early October, is easily recognized. Allergic rhinitis, subclinical hay fever, or dust allergies may simulate the common cold. Chronic sinusitis often is the result of undiagnosed allergies.

Allergy is a condition of altered reactivity in response to a specific stimulant. It is an altered reactivity because it is a hypersensitivity to a substance which does not normally affect nonallergic persons. Fifteen to 20% of the population suffer major allergies;[1-2] another 20-30% have less severe allergies.[3] Thus, while about half the population have some form of allergy which warrants treatment, less than one-fifth of the patients who enter a physician's office receive such treatment.

Possible allergic conditions seen in the office include hay fever, perennial rhinitis and sinusitis, asthma, irritable bowel syndromes, and dermatitides, such as poison ivy, eczema, and hives.

Many over-the-counter cold remedies owe their effectiveness to the antihistaminic ingredient controlling the symptoms of an allergy rather than effectively treating a cold. Their failure after prolonged use usually is due to increased tolerance to the antihistaminic preparation. Often it is when these preparations fail that the patient comes to the physician for treatment of his "cold."

After a cursory examination of the chest, a brief look at the throat, and the observation of swollen, grayish-red turbinates in conjunction

with a clear or slightly yellowish mucous discharge, the physician makes a diagnosis of upper respiratory infection and prescribes antibiotics and nasal decongestant. The patient's subsequent improvement is not necessarily because of the antibiotic but possibly because the disease itself is self-limiting or the nasal decongestant has relieved his symptoms. The relief is not long-lasting, however, and the patient may again be incapacitated a few weeks later by another "cold."

Such patients should be evaluated for possible allergies.

Allergy can be treated. It should not be scoffed at or be passed over in the belief that there is no effective treatment. Untreated asthma can result in emphysema and severely limit the patient's activity. Untreated perennial rhinitis can progress to formation of nasal polyps, causing difficulty in breathing and possibly recurrent sinusitis. Untreated gastrointestinal allergies frequently create irritable bowel conditions and possibly colitis.

Treatment of allergy depends upon the early recognition of symptoms, the prompt diagnosis of the precipitating agent, and the institution of effective therapy.

Early recognition of symptoms depends upon the physician's interest in the patient's condition, his curiosity about the cause of the patient's symptoms, and his awareness of allergic conditions. Chronic sinusitis does not occur without a reason, just as no other disease occurs without a reason.

If the patient reports that his sinus difficulty begins as soon as the heat is turned on in the fall and is relieved when the heat is turned off in the spring, the physician should consider the possibility of an allergy to house dust. If a child has a running nose all winter, is irritable, and does not eat adequately, allergic nasal rhinitis should be suspected. Allergic bronchitis should be considered in the child with eczema, recurrent bronchitis, and pneumonia. Nasal congestion, watery eyes, and sneezing during May and June signal grass allergy or grass hay fever; the same symptoms occurring in March and April suggest tree pollen hay fever. The patient who has asthma attacks only during wintertime should be evaluated for allergy to house dust. Sneezing brought on by being in a damp basement might be caused by a hypersensitivity to molds.

The symptoms described by the allergic patient depend upon several factors. They include the particular antigen which stimulates the allergy; the concentration of that antigen to which the patient is sensitive and exposed; the shock organ or organs of the patient in which the antigen-antibody reaction will take place; the route by which an antigen enters the patient's system; and the response of that shock organ to the antigen-antibody reaction. House dust, for example, may precipitate sinusitis or nasal allergy in one patient yet cause rashes, asthma, or gastrointestinal disturbances in other patients. Ragweed not only causes hay fever but also may precipitate asthma. Grass may cause hay fever or it can be the cause of skin rashes. Food may cause eczema in one person, hives in another, asthma in a third person, and gastrointestinal disturbances in a fourth person. The nature of the allergic symptoms does not point to the responsible agent; further investigation must be made.

A careful history is necessary to determine the frequency of attacks, whether they occur seasonally or the year around, and whether they occur in a particular environment or under particular circumstances. Emotional conditions may precipitate an allergic reaction, but they do not cause the allergy. The patient is born with the tendency toward allergy. The development of an allergic reaction depends upon whether he is exposed to the particular stimulant to which he is sensitive. A patient's allergic condition may change during life. The child with eczema may develop hay fever in his teens and asthma in his middle age. The child with colic later may develop asthma. The child with recurrent bronchitis or frequent episodes of pneumonitis may have an allergy which is only diagnosed several years later when he develops an acute asthmatic attack.

No one outgrows his allergy. It may remain dormant for years, only to reappear when the patient enters a new environment or is exposed to high concentrations of the antigen to which he is allergic.

The diagnosis of allergy extends beyond the listing of symptoms. The ultimate diagnosis lies in identification of the offending substance based on history, physical examination, and skin tests. None of these alone is sufficient to firmly diagnose the agent responsible for a patient's allergy.

History

When an allergy is suspected, the history should be extensive and directed toward those factors which might precipitate the allergy. It should include the chief complaints, the age at onset of the allergy, whether it is seasonal or non-seasonal, paroxysmal or continuous, environmental or non-environmental. The physician should ask about other associated complaints, such as other allergies in the past or present, the age at onset, and the age at which they ceased to bother the patient. He should ask about the frequency of respiratory tract infections and particularly about operations on the respiratory tract. He should inquire into the family history for allergic conditions in both antecedents and children.

A description of the patient's attacks, including frequency, duration, and severity, should be obtained. It should be ascertained whether there are some particular disturbing factors, such as environment, seasons, diet, drugs, upper respiratory tract infections, or menstrual relationships. It is worthwhile to ask the patient what he thinks is the cause of the allergy. It is useful to know what drugs the patient has used in the past and which have provided relief.

The history should include an extensive review of the patient's general condition: whether he has gained or lost weight; whether he suffers from fatigue or digestive attacks. The diet should be reviewed in detail. Particular note should be made of those foods which might precipitate attacks in the patient, which foods the patient avoids because of consequent discomfort and the type of discomfort.

Questions pertaining to the patient's environment should disclose whether the attacks occur in different environments or whether they occur just at night when sleeping, or when housecleaning, or while at work, or at the zoo, or near horses, dogs, or cats, or whether they are precipitated by insecticides. In women it is important to learn whether the attacks occur when putting on makeup, since some of the base ingredients of cosmetics contain allergenic substances.

Such a detailed history provides important clues to the possible causes of the allergy.

Physical Examination

A careful and complete physical examination with an evaluation of all systems should be performed. Particular attention should be given to the nose: look for changes in the mucous membranes, for polyp formation, or for other evidence of chronic nasal rhinitis. Translumination of the frontal sinuses is particularly useful for screening sinus conditions.

Examination of the ears should include an evaluation of air and bone conduction. Look for evidence of hearing loss due to recurrent nose or ear infections.

A careful examination of the heart should be performed, since wheezing due to heart conditions is not easily distinguished from allergic asthma. Respiratory wheezing and hyper-resonance to percussion suggest long-standing asthma. Measurements of the circumference of the chest, both in deep inspiration and in expiration, should be made to see if any limitation of the chest wall exists. The skin should be thoroughly examined for rashes or other lesions. A careful psychological evaluation should also be made.

Laboratory studies should include more than a routine complete blood count and urinalysis. A serum protein determination sometimes points to hypo- or agammaglobulinemia as the source of recurrent nose and throat infections. A smear of the nasal mucosa for eosinophiles aids in the diagnosis of perennial nasal rhinitis. Eosinophilia in the peripheral blood, in the absence of parasite infections and other possible causes, would suggest allergies.

A chest x-ray is mandatory to evaluate the pulmonary status in the asthmatic patient. All patients over 30 with asthma and all patients over 35, regardless of their condition, should have a routine electrocardiogram. If asthma is suspected, the patient should undergo pulmonary functions studies to determine his maximum breathing capacity and changes in the residual lung volume and one-second respiratory volume. This should be done before and after the use of a bronchial dilator.

Skin Testing

Extensive skin testing is seldom necessary if a careful history has been taken. A thorough review of the patient's dietary habits aids in determining which foods precipitate allergic symptoms obviating the need for skin testing to foods.

Skin testing to foods often is unreliable,

since many patients with known allergies to certain foods produce negative skin reactions. Other patients with positive skin reaction to certain foods may have no symptoms even when devouring large quantities of that food. An elimination diet often is more effective in the identifying food allergies.

Several hundred substances are available for skin testing. These include pollens, inhalants, and contactants. Usually a logical selection of suspected antigens can significantly reduce the number of skin tests. Testing a Maryland resident to substances that are prevalent only in the far West is unnecessary, as is testing patients to substances with which they are in frequent contact which produce no symptoms. The most common substances to which patients in this area are allergic are listed in the box. This selection of antigens has been used successfully for several years at the New York University Allergy Clinic. Rarely do they have to expand this list to other substances.

INHALANTS

as used in Allergy Clinic,
New York University
Bellevue Medical Center

T & O	Horse Epithelium
Plantain	Cat
Ragweed	Horse Serum
Dust	Pyrethrum
Rabbit	Kapok
Feathers	Flaxseed
Orris	Atternia
Cottonseed	Aspergillus
Tobacco	Penicillium
Dog	Hormodendrum
	Silk

The manner of testing depends upon the physician's attitude and his experience in the type of skin testing. For several years I have used only the intradermal skin testing technique with excellent results. I find this technique more accurate and dependable than the scratch test. When done properly, it is no more painful than the scratch test, and it is as effective in children as in adults.

Sufficient caution should be taken to prevent anaphylactic reactions or severe local reactions. When a contact allergy is suspected, suitable kits are available to diagnose them by means of patch tests. These are useful only in determining what substance causes a particular type of contact dermatitis.

Some extracts may be eliminated from testing when the patient's symptoms suggest a particular substance. For example, the patient who has symptoms only between August 15 and the beginning of October does not need a whole series of skin tests to determine allergy to ragweed; nor does a patient who has symptoms only during April, May, or June warrant a whole series of skin tests. If the physician suspects that other substances might potentiate a pre-existing allergy, then it is helpful to determine what other substances might precipitate or aggravate the allergy during that particular season. Therefore, depending on the patients' history, it might be necessary to test for only one or for 20 substances. Beyond that, the results show diminishing returns.

The severity of a patient's allergy can be classified according to the degree of allergic response to a particular antigen. A suitable testing level is 100 protein nitrogen units (PNU). This provides a base line at which it is necessary to begin. If the patient has a severe reaction at this level, then a lesser dosage should be used to determine the lowest concentration which will provide the most reaction. The patient can then be placed into Class A, B, or C (as shown on Table 6). The treatment will be provided on the basis of this classification.

Therapy

If the symptoms are minimal and easily controlled with antihistamines, hyposensitization is often unnecessary. This is particularly true with seasonal allergies. But when the allergy is perennial, increased tolerance to the antihistamine and the frequent changing of antihistamine preparations often necessitates hyposensitization of the patient. In some instances of seasonal allergy, changing of antihistamine preparations may be necessary to find that preparation which will provide greatest relief for the patient. Different patients have different responses to the same antihistamine preparation.

The inherent dangers of corticosteroids, despite their refinement and varied programs, restrict their use to extreme emergencies. Long-

term corticosteroid therapy should be avoided. It should be used only as a last resort and then reluctantly.

One program of corticosteroid therapy which is highly effective in controlling acute episodes of allergy, particularly seasonal allergy, is the use of decreasing doses of prednisone, beginning with 30mg and reducing the dose at the rate of 5mg a day. This often controls symptoms throughout the season, despite the fact that the therapy is instituted for only a week. This should not be used routinely each year at the onset of the patient's allergic season, however, since it immediately creates a dependence upon the drug and gives the patient a false sense of security. Even at this low dosage some patients have developed hyperglycemia and glycosuria or hyperacidity.

Steroids should not be used in patients with known ulcers or history of ulcers. They should be avoided in cardiac patients, since most preparations cause sodium retention.

The patient receiving steroid therapy should be encouraged to undergo hyposensitization treatment. In some patients it may be necessary to anticipate long-term corticosteroid therapy. They should be given the lowest possible dose to control symptoms, and during the periods of steroid therapy, they should be given ACTH. Recent evidence indicates that providing the total for two days at one time, every other day, reduces the frequency of side effects but maintains equal effectiveness. It does not, however, reduce the need for the amount of steroids. Its effectiveness lies in its reduction of certain side effects, such as incidence of peptic ulcers, osteoporosis, and Cushingoid symptoms. A careful follow-up of cardiac, renal, adrenal, and bone status should be maintained in patients on long-term steroid therapy.

Hyposensitization

There are three basic forms of hyposensitization. The oldest type is multiple injections, requiring twice weekly injections of an aqueous antigen in gradually increasing doses. This technique has not been universally effective, possibly because of the low dosage given the patient, or failure of the patients to maintain regular appointments for their therapy, or for other reasons to be mentioned later.

In the 1940's Loveless introduced a repository one-shot therapy for controlling allergic symptoms. The program was further expanded and given greater impetus by Dr. Ethan Allen Brown in the 1950's; but this technique is still under investigation and is not available for general use, nor will it be unless certain practical problems concerning the preparation of the material and local and systemic reactions are resolved.

Initially the repository form of treatment was based on giving a high dose of a slow-releasing emulsified antigen, and this gradual release would provide increasing protection to the patient. Some investigators have altered this program by giving up to four injections during the year.

Another difficulty is that the emulsified preparation is not stable for long periods of time and it must be mixed with a particular machine to provide a precise emulsion. This is inconvenient for the average physician. Some pharmaceutical houses are investigating emulsions which have been stable for long periods of time, but their effectiveness has not been clearly defined.

Complications in the emulsion therapy include marked systemic reaction, due to the sudden release of high doses of the antigen. Several patients have developed sterile abscesses at the site of the injection.[5]

More recently, Strauss and Fuchs[6] introduced a pyridine-extracted, alum-precipitated aqueous suspension of the antigen. In 1959 they presented studies on the effectiveness of this preparation in the treatment of hay fever, particularly in patients highly sensitive to ragweed pollen. Their patients tolerated higher doses of the extract and required less injections. Subsequent studies have shown this preparation to be more effective than the previous aqueous preparation and to have fewer systemic reactions or untoward side effects. Interestingly, the eye symptoms of hay fever were greatly reduced, while the nasal complaints were only moderately reduced in some patients.

The practice of having patients receive hyposensitization injections from office nurses without ever seeing the physician, except during the initial examination and diagnosis, should be condemned. The antigen used is potent enough to precipitate sudden anaphylactic reactions and, in some cases, immediate death. If in error a dose larger than that recommended is given to an al-

lergic patient, a severe systemic reaction might occur.

Proper treatment of the allergic patient calls for careful consideration of the whole patient. Simple administration of hyposensitization shots is not enough; the physician must know of possible local or mild systemic reactions occurring after the patient left his office. He should inquire about symptoms the patient might have had during the period between injections, and he should adjust the dosage accordingly.

The physician himself should be completely familiar with the nature of the substance which he is injecting, the concentration, and the frequency of injections. This work cannot be accomplished by the nurses. Furthermore, a patient may have questions about his illness or the therapy which the nurse is not prepared to answer.

The physician who does not understand the purpose of the therapy, the expected results, and the treatment of reactions as they occur should not treat the allergic patient with hyposensitization shots, no more than a physician should perform major surgery without ever having held a scalpel in his hand. Any physician who is providing hyposensitization therapy to a patient should be prepared to treat any emergency which arises. He should have available in his office oxygen, adrenalin, cortisone, an intravenous setup of glucose and water or saline, a tourniquet, and an airway. These are necessary for the acute anaphylactic reactions which may follow injections and for possible resuscitation. Without such equipment the physician not only endangers the life of his patient but also exposes himself to lawsuits.

Evaluation of Alum-precipitated Extracts

Over a two-year period, I found that the alum-precipitated extracts had many advantages over the aqueous extracts. During that period I treated 32 patients with allergic disorders. Eighteen had first received treatment with aqueous extracts for one year and then were changed to pyridine alum-precipitated extracts. In 14 patients, pyridine alum-precipitated extracts were given initially.

The degree of improvement was classified on the basis of decrease or cessation of symptoms or prolongation of intervals between symptoms. Patients who showed moderate decrease in the severity of symptoms or had more than 50% reduction in number of allergic attacks were classified as *good*. Patients who had complete cessation of symptoms or who showed 80% or more reduction in allergic reactions were classified as *excellent*. Table 1 shows the response to treatment. There were no patients who failed to respond to treatment.

Table 1
RESULTS WITH PYRIDINE EXTRACTS IN 32 PATIENTS

Condition	Degree of Improvement	
	Good	Excellent
Allergic rhinitis	4	6
Asthma	3	5
Hay fever	—	10
Multiple allergies	1	3
Totals	8	24

Table 2
RESULTS WITH AQUEOUS EXTRACTS IN 18 PATIENTS

Condition	Degree of Improvement			
	None	Fair	Good	Excellent
Allergic rhinitis	2	2	1	1
Asthma	1	2	1	1
Hay fever	1	1	3	1
Multiple allergies	0	0	1	0
Totals	4	5	6	3

Table 2 shows the results with aqueous extracts used initially in 18 of the patients. A comparison of improvement from the use of pyridine extracts with that from aqueous extracts is given in Table 3.

Therapy was provided according to the schedule shown in Table 4. A basic series of 8-10 in-

Table 3
COMPARISON OF IMPROVEMENT USING AQUEOUS AND PYRIDINE EXTRACTS

Degree of Improvement	Aqueous	Pyridine
None	4	0
Fair	5	0
Good	6	8
Excellent	3	24
Totals	18	32

Table 4
PRESEASONAL TREATMENT SCHEDULE WITH PYRIDINE EXTRACTS (in PNU)

Injection	Class A	Class B	Class C
1	10	20	50
2	20	50	100
3	40	100	300
4	80	200	700
5	150	400	1,500
6	300	800	3,000
7	600	1,500	5,000
8	1,200	2,500	10,000
9	2,400	4,000	

Class A—Marked skin test reaction to 10 PNU/cc
Class B—Marked skin test reaction to 100 PNU/cc
Class C—Marked skin test reaction to 1,000 PNU/cc

jections was required to reach a top dose for the class. Three patients were able to tolerate 15,000 units without appreciable side effects. All patients were able to reach the maximum suggested dosage for their classification and to be maintained at this level with monthly injections. In only one patient did the dosage have to be reduced during the season of his allergy.

Table 5
IMPROVEMENT ACCORDING TO SEVERITY

	Aqueous	Pyridine
Class A	0	4
Class B	4	6
Class C	6	8
Totals	10	18

Of the 18 patients first treated with aqueous extracts, only 10 showed improvement. When transferred to the pyridine extract, all showed improvement (Table 5).

Table 6 shows the reactions to the injections.

The delayed systemic reaction which occurred in one patient with pyridine was in the form of a mild asthma attack approximately three days after injection.

I found the pyridine alum-precipitated extracts advantageous because they improved conditions previously refractory to aqueous extracts; all patients receiving it showed some degree of improvement. The frequency of side effects was minimal. Three children formerly receiving aqueous extracts preferred the pyridine extracts because of the absence of pain at the site of injection.

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Silver Spring, Md.

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Table 6
REACTIONS TO EXTRACT

	Aqueous	Pyridine
Acute systemic (less than 24 hours)	1	0
Delayed systemic (over 24 hours)	0	1
Mild local (local erythema)	10	6
Moderate local (small hives)	1	2
Severe local (large hives)	2	0
Total	14	9

In Diverticulitis...

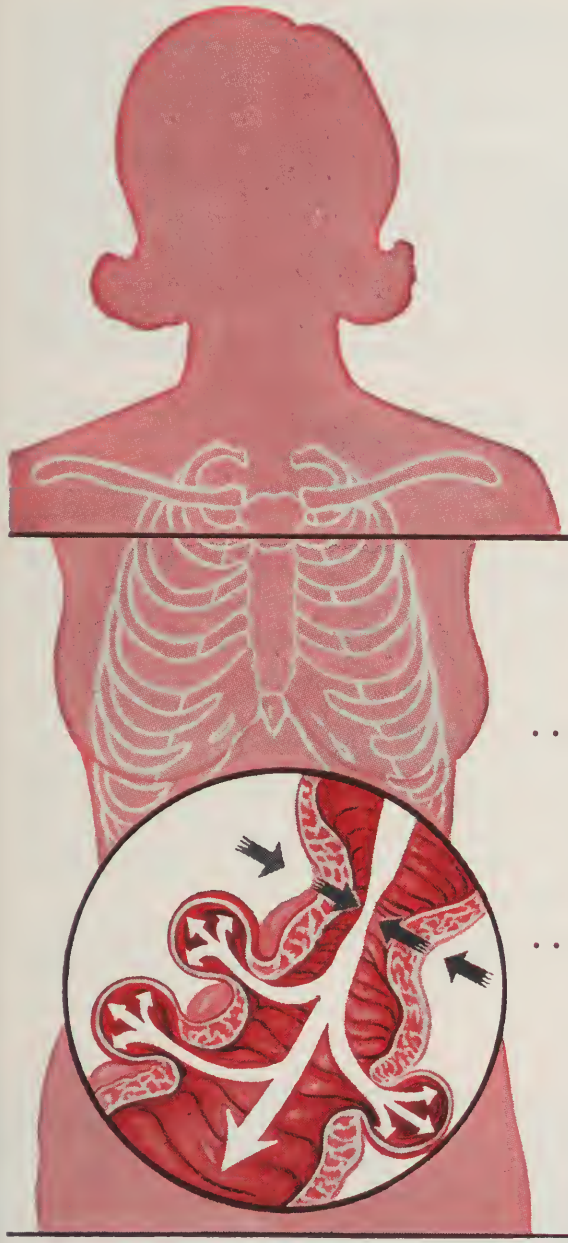
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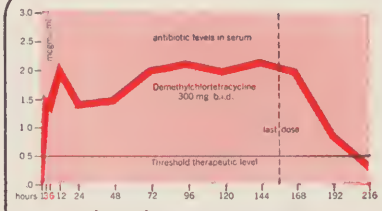
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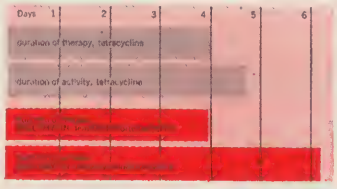
600 mg versus 1,000 mg



higher activity

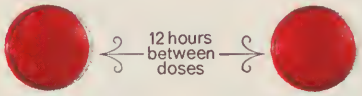
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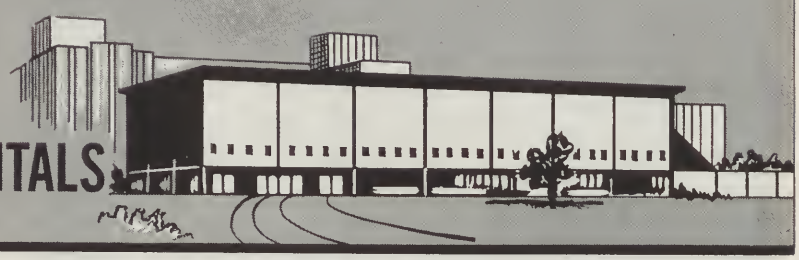
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HISTORY OF THE BALTIMORE CITY HOSPITALS



BY DOUGLAS CARROLL, M.D.

Chapter 8.—The Bayview Asylum: Clinical Medicine (1911-1934)

For the first time in human history, a random patient with a random disease consulting a doctor chosen at random stood better than a 50-50 chance of benefiting from the encounter. (Lawrence Henderson referring to the years 1910-1912.)

Beginning of Modern Medical Era

Late in 1905, Dr. William Osler was making his last ward rounds at the Johns Hopkins Hospital before departing to become Regius Professor of Medicine at Oxford University. After he had seen and discussed the last patient, he turned to a young resident, handed him his stethoscope, and said, "Now carry on my work." The young man was Dr. Thomas Boggs who, in 1910, 10 years after his graduation from The Johns Hopkins Medical School, was appointed by the Johns Hopkins School of Medicine to become chief of medicine at the Bayview Asylum on the eve of completion of its new hospital..[1]

A second and equally important appointment was that of Dr. Arthur Shipley. A brilliant student, he went on to become resident in surgery and finally superintendent of the University Hospital. He reorganized the surgical service there and helped modernize the medical school. In the year that he was president of the Baltimore Medical Society (1910), he was appointed surgeon-in-chief at the Bayview Asylum and went about reorganizing the surgical service.

The influence of the Medical School of the

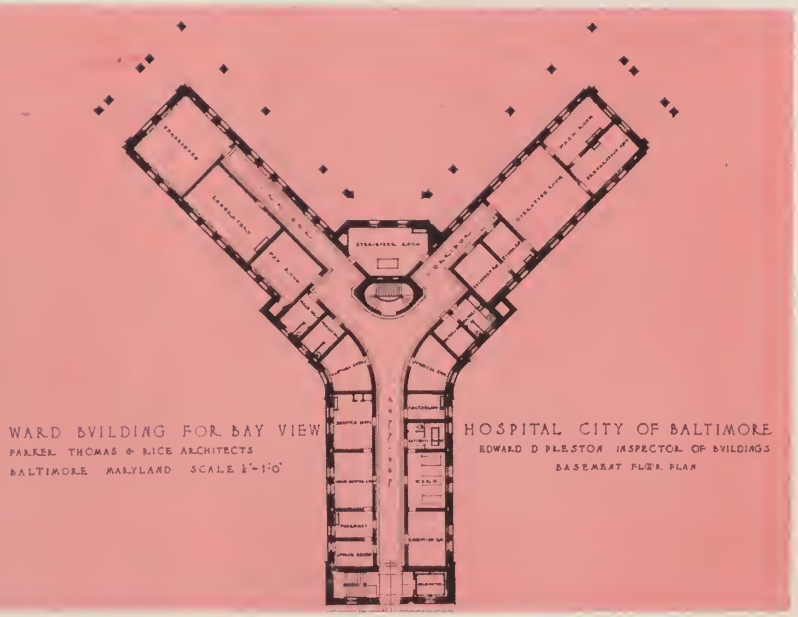


Fig 1

Plan of the New Acute Hospital (B Building) 1910. This acute hospital building resulted from the recommendations of a Board appointed by Mayor Barry Mahool in 1908. It contained four floors. The building was to be the first of four identical buildings, radiating from a central administration building which was to connect at the foot of the Y. This (present B Building) was the only unit completed.



Fig 2

Dr. William Osler's Visit to Bay View Asylum in 1913. Left to right: Drs. Thomas Boggs, William Osler, Palmer H. Futcher, Arthur Shipley.

University of Maryland on the Almshouse goes back to at least 1810. Other appontments were Dr. Milton Winternitz as pathologist-in-chief, Dr. Gordon Wilson as chief of the Tuberculosis Sanitarium, and Dr. Esther Richards as psychiatrist-in-chief.

On July 1, 1911, the new medical and surgical wards were opened in what is now the south wing of the B Building. Architecturally, the hospital was in the very forefront of hospital construction for the time. On the first floor, a surgical suite occupied the southwest wing, while clinical laboratories took up the southeast wing (Fig 1).

The following years were productive of good medical care and house staff teaching. Dr. Boggs was particularly interested in the house staff and the students. His book plate showed an old and a young ox pulling a plow together with the legend *A BOVE MAJORE DISCIT ARRARE MINOR* (The young ox learns to plough a straight furrow by working beside an old ox) (Fig 3).

Dr. Boggs was a capable botanist, an outstanding clinician, and a stimulating teacher. During the First World War, he served as chief medical officer in Base Hospital 18. In 1937, he became president of the Association of American Physicians.[2, 3]

It was sometime after the First World War that the better hospitals became accepted as places to regain health rather than places to die. Improved methods of diagnosis, such as x-ray photography, basal metabolic rate determination, and operating rooms made it essential that the patients come to the hospital for serious illnesses. In a previous age, medical practice consisted of the physician's interview and examination at the bedside. His only resources were carried in a small bag, and cheap high quality care could be rendered in the patient's home. With the development of complicated diagnostic measures, it became necessary for the seriously ill patient to come to the hospital.

Another influence changing the attitude toward the hospitals was the understanding, development, and control of infections. Introduction of antiseptic and, later, aseptic techniques made hospitals increasingly safe places for treatment. At first, the private hospitals were largely filled with surgical patients. In the nineteenth century, medical patients were still taken care of at home by their family doctor.[4]

In October, 1911, a nurses training school was opened.

A number of problems plagued the institution. A new problem was insufficient living space for nurses and doctors. The old chronic problem of insufficient patient space remained.

In 1913, there was but one telephone to the three hospitals (infirmary, tuberculosis sanitarium and B Building) with a population of 1,500 people. There were increasing needs for laboratory examinations and particularly for an X-ray Department. During 1916, the increasing number of admissions of insane patients made the hospital even more crowded.

During World War I, because of the shortage of physicians, fourth year medical students were called on to care for patients. In 1917, both Dr. Boggs and Dr. Shipley left for service in

the Medical Reserve Corps. In the same year, Dr. Winternitz left to become professor of pathology at the Yale Medical School. Dr. Boggs was replaced by Dr. Thomas Sprunt, who was later replaced by Dr. Charles Austrian. In 1919, Drs. Boggs and Shipley returned to find a new X-ray Department installed, but so typical of poor coordination, there was no salary for a technician. In the 10 years after the war, Drs. Boggs and Shipley, helped by a number of other physicians, continued the work of patient care and teaching.

In 1925, the name of the Bayview Asylum was changed to Baltimore City Hospitals. This change recognized on the one hand the decreasing number of insane patients being cared for and, on the other, the growing medical care being rendered to the poor both on the wards and in the Outpatient Department. Doctors Boggs and Shipley reported in 1926, "The Chronic Wards have been expanded beyond the limits of propriety and strict honesty. . . . This situation is an urgent reality. . . . It is impossible to maintain morale. . . . The city will not do its duty toward the sick poor. . . . First and last the solution lies in adequate personnel, adequately paid."

Over the next few years, with increasing difficulties, the work was carried on. As has so often happened in the history of the hospital, the buildings were allowed to deteriorate, morale was allowed to fall, and complete deterioration of the organization was in view before the situation was faced.

Finally, in 1929, overall plans were made to construct a new general hospital, tuberculosis sanitarium, service building, and nurses' home.

In 1924, a plea was made for social service in the hospital. The question was asked as to what could be done to re-establish patients in the community. The use of social workers, cooperation with other agencies within the city, and occupational therapy within the hospital were recommended as measures to help patients reach the point where they could care for themselves.

In 1927, the needs of the hospital were forcefully presented by the staff. The point was made that Baltimore paid less per day for the care of its welfare patients than any other large city in the country. Three years later, the city responded by expanding its facilities and buildings and meeting its responsibility of housing the sick poor.



Fig 3
Bookplate of Dr. Thomas Boggs.

In the 1928 report, Superintendent Longan outlined the functions of the municipal hospital as 1) the appropriate care of patients, 2) teaching of all types of hospital personnel, and 3) contribution to medical knowledge through properly kept records and research.

The period from 1911 to 1934 at the Baltimore City Hospitals was characterized by the practice of superior bedside medicine. The physicians who were leaders at the Baltimore City Hospitals were the flower of American medicine. Dr. Boggs became president of the Association of American Physicians, the highest accolade in American medicine; Dr. Shipley had been president of the Baltimore City Medical Society in the year of his appointment to the Baltimore City Hospitals (1910); Dr. Gordon Wilson was one of the leading phthisiologists of America; Dr. Milton Winternitz became professor of pathology at Yale; Dr. Esther Richards remained a leading American psychiatrist throughout her life. All of these physicians were particularly interested in the professional training and personal success of their house staffs. Young doctors from across the United States came to work at the Baltimore City Hospitals.

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WASHINGTON COUNTY

May 19 was Ladies' Night. The members of the Washington County Medical Society invited their wives for cocktails and dinner. They heard a most interesting talk by **E. T. Lisansky, MD,** on "How to Take a History." He played a taped interview with a patient to illustrate how best to obtain information about the patient's symptoms and his background. Dr. Lisansky is associate professor of medicine and clinical psychiatry at the University of Maryland.

A special guest was **Mrs. Anna Mae Marshall,** who recently retired from nursing duties at the Washington County Hospital. She was presented with a plaque from the Washington County Medical Society in honor of her 30 years of service to the hospital, patients, and physicians of Washington County.

A resolution of respect in memory of **Walter Hal Shealy, MD,** who died on April 15, was read and made a part of the permanent records of the Society.

* * * * *

The Washington County Medical Society will cooperate with the Mayor's Council on Problems of the Aging. Its first project was approving the use of a hearing testing trailer for older citizens during the summer months. **George Comstock, MD,** has been appointed to represent the Society on the Advisory Committee to this Council.

* * * * *

E. W. Ditto, III, MD, chairman of the Physicians Procurement Committee, has interested several young physicians in coming to Hagerstown to practice medicine.

* * * * *

Johns Hopkins Hospital is conducting a research project, "Genetic Studies in Washington County." The purpose is to determine the frequency and type of hereditary diseases in our county. The investigators are **Mohsen Mahloudji, MD,** and **Bruce Konigsmark, MD.**

* * * * *

The Medical Technology Resolution 2A/66, initiated by **Frederick W. Shillinger, MD,** of the Pathology Department of the Washington County Hospital, was adopted unanimously by Med-Chi at its annual meeting on April 29. This resolution concerns training for medical technologists at the college level.

* * * * *

Mary Ann Prisak, a recent graduate of North Hagerstown High School, was the recipient of a scholarship awarded annually by the Washington County Medical Society. Miss Prisak plans to study medicine and will enter the University of Maryland this fall.

* * * * *

Archie Cohen, MD, has assumed office as a Councilor of the Medical and Chirurgical Faculty from this area.

John W. Clark, MD, DDS

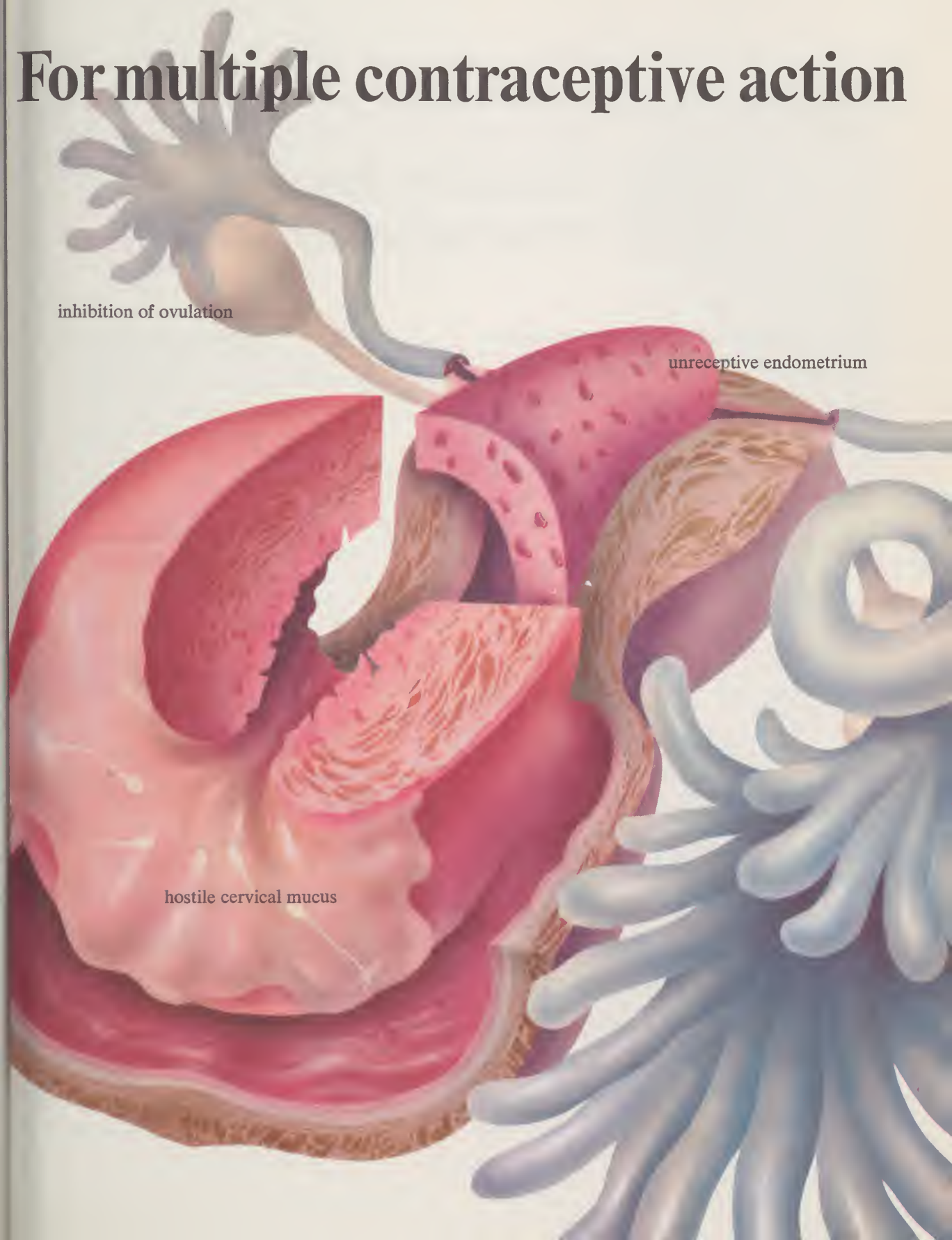


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Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

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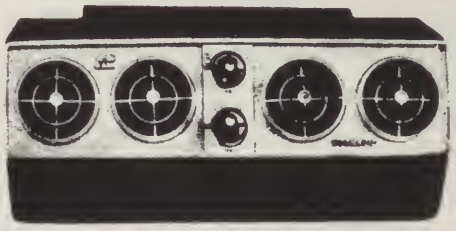
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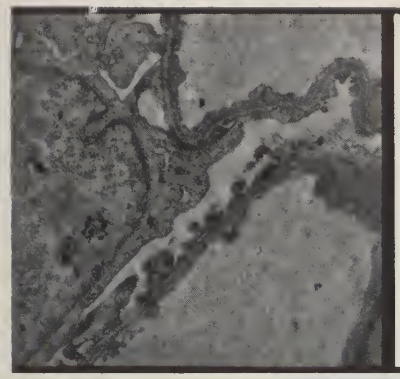
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Automated systems are under development in several medical centers, where all the paper work related to specimen handling (work lists, etc.), test result calculations, and printing of reports is handled by a data processing system.[1, 2]

In other laboratories, equipment has been designed to include automatic accessioning of blood samples by machine and subsequent identification, chemical assay, computation of results by scaling to appropriate standards, and print-out of complete reports. Processing is handled entirely by machine and computer.[3, 4]

Computer programs have been written to compare the new test result with the previous result on the same patient and to print out a warning if the difference exceeds accepted normal range or predetermined limits. Other useful programs to evaluate laboratory data and thus assist the clinical pathologist and patient's physician are being developed.[5]

These innovations in laboratory medicine will greatly increase the value of clinical pathology in every day medical practice and permit the every day use for patient care of many sophisticated procedures previously limited to research.

The same advances in automatic laboratory systems which can serve us so well make it possible for business and industry to enter the field of clinical laboratory services and provide reliable quality controlled test results. Already several industrial corporations are organizing to offer laboratory service at costs not subject to the expenses of training residents, absorbing charity work, teaching medical students, training technologists, and providing clinical pathology consultation. Particularly during the next few years, when the Medicare program produces enormous demands

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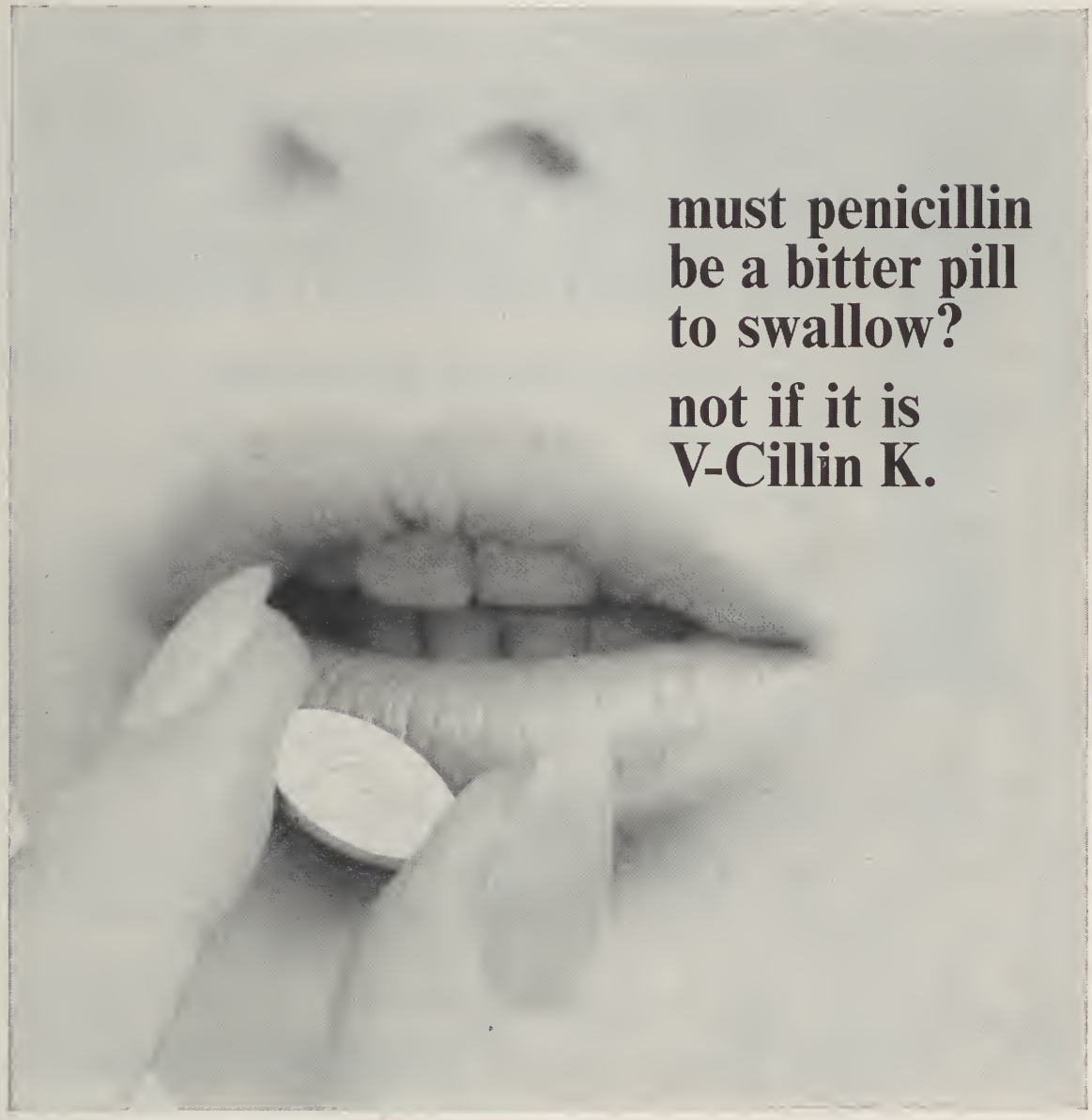
for laboratory work which cannot be immediately met by existing clinical pathology laboratories, there will be ample opportunity for industrial and commercial laboratories to develop their assay business. However, they can never provide the most important constituent of a clinical pathologist's contribution to comprehensive laboratory care of the patient: that of interpretative consultation based on medical training, and familiarity with the medical history and current physiology of the individual patient.

More and more in the future, the chemical, hematologic, immunologic, and genetic data for any one patient will grow in volume and complexity ("molecular" diseases, genetic biochemical anomalies, endocrinopathies, metabolic changes, physiologic homeostatic states) requiring knowledgeable correlation and expert formulation into profiles and patterns useful to the bedside physician. This is the clinical pathologist's most important task; he must attain surpassing excellence in this aspect of laboratory medicine. This essential professional service to the patient's physician can never be provided by anyone other than a well-trained laboratory physician.

Thus, we clinical pathologists must develop still further our skills and intimate knowledge in pathologic physiology, chemistry, and biology, and in the correlation of complex patterns of tests and their practical formulation for our colleagues at the bedside; we must participate in the consolidation of hospital and private laboratories into groups for more efficient and economic utilization of automation and available skilled technical and professional manpower; only thus can we improve the quality, reduce the cost, and provide the high level of laboratory care every patient needs.

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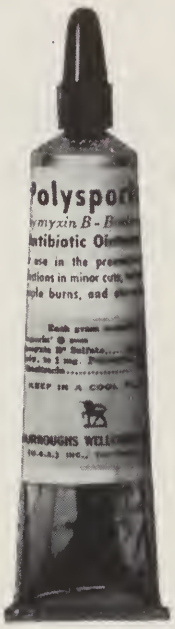
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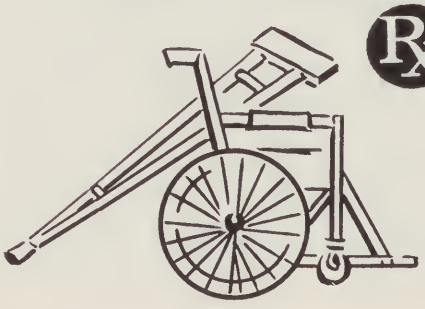
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Myocardial Failure Secondary to Shock

JOSEPH S. McLAUGHLIN, MD
ARLIE MANSBERGER, MD
R ADAMS COWLEY, MD

A rationale for resuscitation of critically ill hypotensive patients based on the correction of pathophysiologic and biochemical derangements is presented. The successful use of this approach to therapy is illustrated to emphasize the problem of secondary myocardial failure in shock.

Shock from myocardial infarction is well known and readily recognized. Not so well known and frequently unrecognized is myocardial failure due to shock. The following case report is an example of myocardial failure secondary to septic shock. It illustrates our approach to therapy as carried out in the Shock Trauma Unit at the University of Maryland Hospital.

CASE REPORT

An 85-year-old Negro man was admitted to the University Hospital with the chief complaint of pain in the left lower part of the abdomen of about two months duration. Physical examination revealed a pulsatile mass in the left lower quadrant of the abdomen. A translumbar aortogram demonstrated this to be an aneurysm involving the left common, internal, and external iliac arteries. The patient's general health otherwise was remarkably good.

On March 4, 1965, with the patient under general endotracheal anesthesia, the aneurysm was resected and replaced with a Teflon prosthesis. The patient tolerated the procedure well and spent a comfortable first post-operation night.

The next morning both feet and hands were cold and he complained of pain in the left leg. The arterial blood pressure was 120/80 and the central venous pressure (CVP) was 3 mm Hg. Vasoconstriction resulting from hypovolemia was adjudged to be present, and two units of plasma were administered. The central venous pressure increased to 10 mm Hq during the plasma infusion, and 2 mg of digoxin was administered intravenously in divided doses. During the next 24 hours there was continued improvement; the pulse and arterial blood pressure remained stable at 100 and 140/90, respectively, and the CVP fell to 4 mm Hg. On the second postoperative day, oral feedings were begun and chair ambulation was well tolerated.

On the morning of March 8, the indwelling

From the Clinical Shock Unit, Department of Surgery, University of Maryland School of Medicine, Baltimore. Supported by U.S. Army Research and Development Command Contract No. DA-49-193-MD-2229.

Foley catheter was removed from the bladder and was later reinserted because of patient's inability to void spontaneously. Later the same morning the patient's blood pressure fell to 80/60 when the attendants lifted him from the bed into a chair. He was returned to bed and given three 5 mgm doses of metaraminol, which brought about transient elevations of the systolic arterial blood pressure to 110 mm Hg. The central venous pressure rose to 6 mm Hg. An electrocardiogram did not indicate myocardial infarction; a chest roentgenogram showed no change from previous examinations. Hypovolemia was again suspected, and 600 cc of plasma was carefully administered. Nevertheless, the blood pressure remained at 80/60. After plasma infusion, the CVP rose to 14 mm Hg. Rales were noted in the posterior lung fields bilaterally, and the patient became anuric.

Eight hours after the onset of anuria, the patient was seen in consultation by a member of the Shock Trauma team and transferred to the Shock Trauma Unit. Initial laboratory examinations revealed a normal acid-base balance and normal electrolyte levels. A diagnosis of septic shock from bladder catheter manipulation was entertained.

Blood cultures were obtained. Hydrocortisone (1 gm), chloramphenicol (4 gm), and digoxin (0.25 mg) were administered intravenously. No improvement occurred, so an isoproteranol infusion was initiated (0.2 mgm in 200 cc of 5% dextrose and water). At an infusion rate of 0.5 μg/min the arterial blood pressure increased to 110/80 and the CVP fell to 8 mm Hg. Subsequently 500 cc of 5% dextrose and water was administered over a 30-minute period with only a slight elevation of CVP.

Anuria persisted despite the water load, and 10 gm of mannitol (50 cc of 20% solution) was given. The CVP rapidly climbed to 12 mm Hg, but throughout the next 45 minutes the patient excreted 25 cc of urine, an amount equal to the entire urinary output for the preceding 12 hours. The CVP rapidly rose to 13 mm Hg but the urinary output during the next hour was 50 cc. In the following hour the patient excreted about 100 cc of urine, the blood pressure rose to 120/80, and the venous pressure fell to approximately 7 mm Hg. Decreasing amounts of isoproteranol were necessary, and the infusion was discontinued after six hours. A unit of plasma and approximately 1000 cc of 0.5 N saline solution were infused during this time.

By the following morning the patient's blood pressure was stable at 120/80, the pulse was approximately 90 per minute, urinary output was adequate, and his overall condition appeared quite good. The blood culture obtained the preceding morning grew *E coli.*

COMMENT

Cardiac failure in hypotensive patients is common. MacLean[1] recently reported hemodynamic data from a series of 20 patients in shock from various causes; in 10 of these patients, cardiac failure was a prominent factor. Our experience has been similar. We have become increasingly aware of the need to support the myocardium, particularly in elderly patients and in persons in septic shock.

Myocardial failure may be the cause (primary myocardial failure) or the effect (secondary myocardial failure) of shock. Primary myocardial failure most commonly results from coronary occlusion and myocardial infarction. The initial muscle injury causes decreased cardiac output and a lowering of blood pressure, which in turn decreases coronary blood flow and further injures the myocardium. Vasopressors may reverse the process by increasing peripheral resistance and arterial blood pressure. Coronary blood flow is increased, and the better nourished myocardium then may compensate for its injury.

A similar vicious cycle may occur in the hypotensive patient without infarction.[2] Decreased cardiac output and blood pressure diminish coronary blood flow, which injures the myocardium and produces a decrease in myocardial contractile force. Diminished myocardial contractile force lowers the cardiac output and the blood pressure even further.

Our approach to the problem of secondary myocardial failure in shock is based on correcting the presenting pathophysiologic abnormalities.[3] First we correct volume deficits and acid-base and electrolyte imbalances to allow the endogenous catecholamines to act effectively. Blood pressure and cardiac output are raised and coronary artery blood flow is increased. Adequate oxygenation

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of the blood is essential. If hypoxia exists or if the patient is laboring in respiration, tracheostomy is performed. Not only do these procedures assure adequate oxygenation but, equally important, they abolish the work of breathing. If the central venous pressure increases abnormally during therapy, digoxin is administered intravenously. If the patient remains hypotensive and the central venous pressure continues to rise, circulatory support by adrenergic stimulating drugs is indicated.

Two types of adrenergic receptors exist in the human circulatory system.[4] Alpha receptors produce peripheral arteriolar constriction but have no direct effect on the myocardium. Beta receptors produce arteriolar dilatation and have a positive ionotrophic effect on the myocardium. Since vasoconstriction and decreased tissue perfusion are two of the pathophysiologic abnormalities in shock, alpha adrenergic stimulating drugs appear to be contraindicated. (Metaraminol acts predominantly by releasing norepinephrine, which is both an alpha and a beta stimulator.) Beta adrenergic stimulating drugs, producing both increased myocardial contractile force and arteriolar dilatation, theoretically should be ideal. Isoproteranol is a beta adrenergic stimulator. In the presented case it increased arterial blood pressure and decreased central venous pressure, indicating increased myocardial efficiency and cardiac output. In addition, the urinary output which had been virtually nil for the preceding several hours increased markedly. Mannitol undoubtedly was largely responsible for the diuresis, but without the improved myocardial function, the additional volume expansion associated with mannitol infusion would have been hazardous.

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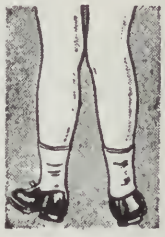
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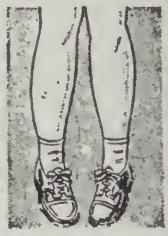
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Uses and Abuses of Bed Rest

There was a young athlete named D.
Who was clapped into bed for TB.
After months in the sack,
He had pains in the back,
And his bones turned to stones in his P.

The advent of Medicare and the Utilization Review in hospitals brings increasing concern about the indications for prolonged bed rest in hospitals. There has been a great deal of talk about the uses and abuses of bed rest but little scientific investigation of its general effects and specific indications.

In a recent excellent publication, Dr. Norman L. Browse,[1] lecturer in surgery at the Westminster Hospital and Westminster Medical School, London, reviewed the physiology and pathology of bed rest. His main purpose was to stimulate research in the physiology of bed rest and to expose its dangers. The book is clinically oriented and reviews recent studies of circulation, ventilation, excretion, and metabolism associated with bed rest.

In hospital planning, the number of beds needed is a leading consideration. Ten times as many patients go through an out-patient department, and many in-patients need the bed only for sleep at night.

The bed is still "king of modern medicine."

The established reasons for prolonged bed rest are to relieve pain, to immobilize wounds and fractures, to overcome the effect of gravity (as in ankle edema or with orthostatic hypotension), and to provide support for people who are completely paralyzed, too weak, or too tired to sit or stand.

Often prolonged bed rest is used without any real evidence that it is of help, as in acute rheumatic fever, pulmonary tuberculosis, liver disease, peptic ulcers, cerebrovascular accidents, and infections after the acute febrile illness is over.

Current medical knowledge offers more proof that bed rest is overused than that it is underused. Some of the deleterious effects of bed rest are thought to be the development of deep vein thromboses and pulmonary thromboembolism, aspiration pneumonia, pressure ulcers, contractures, constipation, difficulty with micturition, renal calculi, osteoporosis, generalized weakness, and depression. Many of these complications, however, may be related to the wasting and deterioration caused by the disease which necessitated bed rest.

Few controlled trials comparing patients on and off bed rest have been performed. Weir[2] compared 200 patients with pulmonary tuberculosis treated with antituberculosis drugs. Half were kept in bed and the other half were ambulatory. There was no difference in the clinical results obtained in the two groups.

A number of studies have been performed in patients with hepatitis to estimate the effect of exercise, but the results are not clear cut between the two groups.[3]

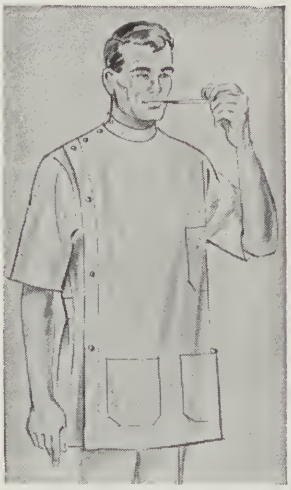
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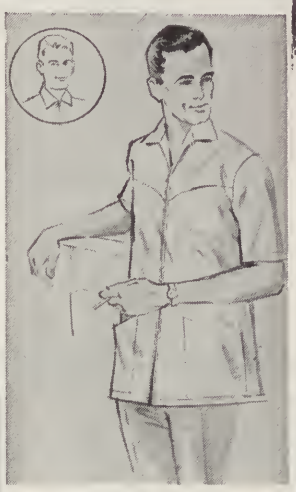
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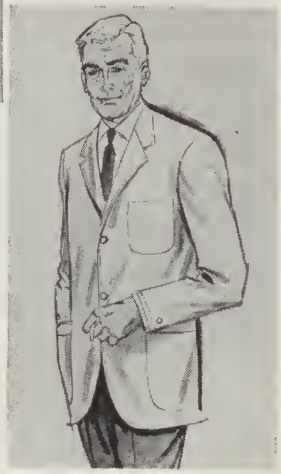
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by bed rest and medical treatment while the healing of the ulcer is observed radiologically. There is no evidence that the bed rest itself has value, although removing the patient from his family and the working environment may be important. Pollard and Summerskill[4] studied 66 patients with melena or hematemesis. Half were mobilized one week after bleeding stopped. There was no difference in the rate of recovery.

In rheumatoid arthritis particularly, we have been shocked by patients arriving in the hospital twisted like pretzels and giving a history of prolonged bed rest with no effort at mobilization of any of the joints.

In 1952, Levine and Lown[6] started a movement toward early armchair treatment of patients after myocardial infarction, pointing out the higher cardiac output and other advantages of early armchair mobilization.

More studies of comparable series of patients, one group treated with bed rest and one without, are needed in view of the need for efficient use of available hospital beds.

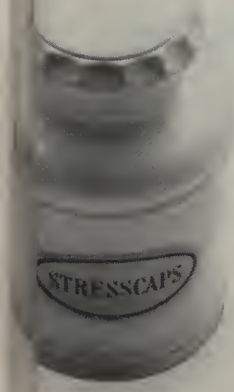
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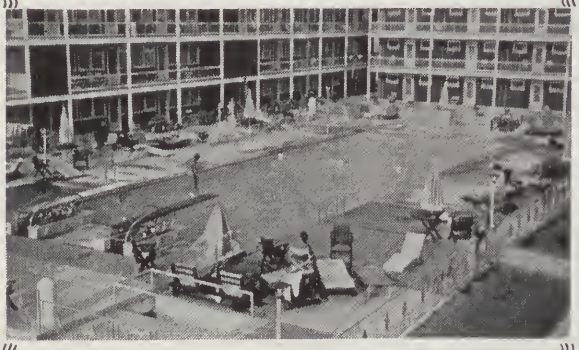
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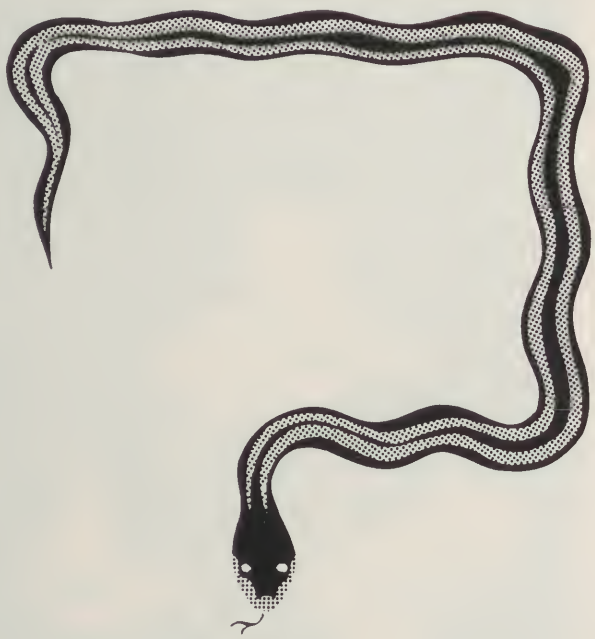
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Anabolic Sex-Related Steroids in Cystic Fibrosis

Methandrostenolone in individualized large dosages produces consistent increments of height and weight in children with severe fibrocystic disease. • Injections of beta estradiol valerate used concomitantly with methandrostenolone has been followed by marked anabolic state where methandrostenolone by itself appeared ineffective. • Norethindrone has resulted in good anabolic response in one case. • Rapid advance in bone age and side effects of androgenization and estrogenization have occurred. • This degree of sex-related anabolic therapy should be used in cases in which the threat to life or chronic invalidism is sufficiently great to warrant development of effects expected in sex hormone therapy in children.

THOMAS A. GOOD, MD
SAMUEL P. BESSMAN, MD

Children with advanced cystic fibrosis of the stand the rigors of their disorder if their nutrition tion. The development of severe anorexia and psychic depression too often heralds death.

To see if these children would be able to withstand the rigors of their disorder if their nutrition were improved, we attempted artificial appetite stimulation with the anabolic steroid methandrostenolone (Dianabol) in a patient who appeared to be in a preterminal stage. This 9-year-old girl showed a striking response in weight and growth, and for a year her acute lower respiratory tract condition improved. Indeed, it was the first year in the past two years that she responded to antibiotics, mist, and postural drainage to the degree that she was virtually asymptomatic. Clubbing of her fingers was greatly reduced, and she enjoyed good health until the steroid dosage was reduced from 10 mg per day to 2.5. She again developed anorexia, weight loss, and lassitude in association with superimposed pneumonitis.

Because reinstitution of 10 mg of methandrostenolone to an intense fibrocystic disease regimen failed to improve her condition after one month, estrogenic therapy was added in the form of injections of 20 mg of beta estradiol valerate (Delestrogen) in oil every two weeks. She responded to this medication, and in the 20 months subsequent to the initiation of combined anabolic androgen and estrogen therapy she has enjoyed good health, withstood several attacks of respiratory infection, and has shown gratifying growth in weight and height. She is taller than her mother and, therefore, will not be dwarfed by the rapid epiphyseal closure that has occurred on androgenestrogen therapy.

Because of this patient's response to methandrostenolone, we have treated a total of 10 patients with similar results. The table summarizes experience with six patients who have been treated for long enough periods to allow evaluation. In two cases estrogens were added, as in the first case. Additionally, the progestational hormone (17 hydroxy progesterone caproate—170HPC) has been used in an effort to delay epiphyseal closure and, perhaps, to change the character and quantity of respiratory mucus production. Patient 2 did not show a good response until 170-HPC was added to the regimen. Patient 3, treated with large dosages of progestational hormone and relatively small dosages of estrogen and ana-

From the Pediatrics Research Laboratory, University of Maryland School of Medicine, Baltimore.

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Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
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*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



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Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

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Patient & Sex	Age R_x Yrs	Drug	Average Dose mg	Mos R_x	Gains		Clinical Lung Infection	X-ray Changes		Bone Age Adv. mo/mo	Coarsening of Features	Acne	Breast Development
					Weight kg	Height cm		Acute	Chronic				
1 ♀	10	M	10.0	14	13.5	15	↓	↓	→	0	++	++	
		M & BEV	7.5 20.	18	16	6	↓	↓	→	36/12	+	+++	++
2 ♀	11	M	10.	6	1.5	2	→	→	→	12/6	+	+	
		M BEV & 17OHPC	10, 20 250	20	13	5	↓	↓	→	42/12	+	++	+
3 ♀	6	M	5	10	6	11	↑	↑	↑	36/12	+		
		BEV, 17OHPC	5, 250	3	0.5	1.5	↑	↑	↑	0			
		M, BEV 17OHPC	5, 5, 250	4	2	3	↑	↑	↑	0	+	+	+
		M, EE	5, 0.02	1	7	0	↑	↑	↑				
4 ♂	6	M	7.5	28	14	18	↓	↓	↑	36/12	+	+	0
5 ♀	10	M	7.5	12	16	14	→	→	→			++	
6 ♂	5	N.E.	5	10	8	15	↓	↓	↓	18/8	0	0	++

M—Methandrostenolone, mg per day, orally BEV—Beta estradiol valerate, mg every 2 wks, by injection
17OHPC—17 hydroxyprogesterone caproate, mg every 2 wks, by injection EE—Ethinyl estradiol, mg per day orally
NE—Norethindrone, mg per day orally

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Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

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K. Merrill Sumey, Resident Manager

bolic steroid, did not rally and died after eight months of combined therapy. Her initial response to methandrostenolone had been good, but because of her young age and marked advancement of bone age on methandrostenolone, we hesitated to use large dosage androgenic-estrogenic therapy when she became apparently unresponsive to methandrostenolone.

In patient 6 we used the progestin norethindrone (Norlutin) to observe the combined effect of an anabolic estrogenic progestational hormone. This child has done remarkably well with rapid spurt of height and weight. Control of acute lung infection has been possible with sodium nafcillin and sulfasoxazole. He has been treated with 5 mg of norethindrone per day for eight months and continues to improve in nutritional state and activity tolerance. Serial x-ray examinations have shown reduction in evidence of cor pulmonale and clearing of acute changes indicative of pneumonia.

The dosage of sex-related steroid hormones used has been greater than the recommended dose for usual cases in which anabolic effects are desired without serious secondary sexual characteristics. Since we are attempting to save children from life-threatening fibrocystic disease and its complications, we have accepted as side effects the expected results of treatment with sex hormones. Estrogens have helped where androgenic anabolic steroid therapy alone has become ineffective.

Other investigators have recently demonstrated that small amounts of anabolic steroids in less severe cases are effective in improving nutritional status in cystic fibrosis without marked androgenic side effects (Dennis and Panos, University of Arkansas). Our experience has shown that for advanced cases in which lower respiratory infections are constantly present, larger dosages are necessary to pull the children "out of the hole" so that they may respond to fibrocystic regimens. As their nutrition improves, they become less troubled with lower respiratory tract infections, even though they continue to harbor flora of staphylococci and pseudomonas.

GENERIC AND TRADE NAMES OF DRUGS

Estradiol valerate—*Delestrogen*
Methandrostenalone—*Dianabol*
Nerethindrone—*Norlutin*

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...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood.
When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.

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IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses. Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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DEPARTMENT OF HEALTH

STATE OF MARYLAND

William J. Peeples, MD, MPH, *Commissioner*

Highlights

COMMISSIONER NAMED TO ADVISORY COMMITTEE

William J. Peeples, MD, has been named to a nine-man advisory committee designed to strengthen relations between the Department of Health, Education, and Welfare and the 50 state health agencies.

In announcing the membership of the newly created committee, Secretary of Health, Education, and Welfare John W. Gardner said the committee would:

- Examine the nature of the existing relationships between the Department and the state health agencies;
- Identify existing problems and proposals for their solution;
- Report its findings to the secretary.

Other members are from New York, Illinois, Georgia, California, Ohio, Pennsylvania, and the District of Columbia.

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ALBERT J. FINESTONE, M.D.
Director of Postgraduate Course

ROCKY MOUNTAIN SPOTTED FEVER

The fact that 10 cases of Rocky Mountain spotted fever had been reported in Maryland by the start of summer, signalled the possibility of a higher incidence this year. Nine cases occurred in the counties and one in Baltimore City.

In May, the State Health Department issued a press release warning the public to avoid areas where ticks are likely to abound, especially during the late spring through the summer months when ticks are most prevalent. Persons who are particularly subject to this seasonal hazard include vacationers, campers, picnickers, sportsmen, and those who work in wooded or bushy areas. The press release described symptoms of spotted fever and advised readers to consult a physician if such symptoms occur.

Since 1930, when Rocky Mountain spotted fever first was recognized in Maryland, 1,262 cases and 180 deaths have been reported from all parts of the state except Allegany and Garrett counties.



METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides*. Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day*.

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Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

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During the last 10 years, there have been approximately 20 cases each year, with two fatal cases in 1962, and one in 1963 and 1964. In 1965, 21 cases were reported for nine counties in the central area of the state and Baltimore City.

MARRIAGE AND DIVORCE STATISTICS

In 1965, 47,345 marriages were performed in Maryland. This is an increase of 4% over the previous year. The number of women who married at 18 accounted for the major part of the increase. In 29,383 ceremonies, at least one party was a Maryland resident; in 17,962, both were from out of state. The number of marriages between two nonresidents was 24 less than in 1964.

Approximately 78% of all brides and 77% of all grooms married in the state last year were married for the first time. Of these, 51% of the brides were teenagers, and approximately 72% of the grooms were under 25.

Absolute divorces and annulments granted in Maryland last year totaled 6,978, a 4% increase over 1964. Approximately 47% of the couples to whom absolute divorces or annulments were granted had been married 10 years or more.

AIR QUALITY CONTROL

Federal funds amounting to $21,868 to supplement the Metropolitan Baltimore Air Quality Survey have been allowed, as well as funds in the amount of $225,000, as of July 1, to continue the survey into fiscal year 1967.

A study planned for the City of Columbia in Howard County has been started with one station at Simpsonville.

CHRONIC DISEASE HOSPITALS

Charles Winnacott, MD, of Salisbury, has joined the staff at Deer's Head State Hospital. He has been in general practice for 17 years. Andrew C. Mitchell, MD, another Salisbury practitioner, also joined the staff. These appointments fill the existing positions at this hospital with licensed physicians.

The problems of obtaining adequate hospital personnel at all levels remain acute. Particularly critical is the shortage of male attendants at all hospitals and the shortage of registered nurses at Montebello. There are also unfilled positions in social service, medical records, and many other areas which seriously threaten full operation.



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

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Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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Learn To Do Your Part In The Prevention Of Disease

New Ambulance Regulations

The City Health Department has adopted new rules and regulations governing the use of ambulances in Baltimore City. Effective July 1, the new regulations implement City Ordinance No. 734, introduced by Councilman James J. Duffy of the 1st District and signed into law by Mayor McKeldin on January 28.

These regulations apply to all ambulances operated in the City of Baltimore with the exception of Fire Department ambulances. In general, they spell out license requirements and procedures for operators, attendants, and drivers, standards of ambulance equipment and maintenance, required and recommended reports, and the continuing inspections to assure compliance. These regulations follow the recommendations of the American Association for the Surgery of Trauma, the National Safety Council, and the American College of Surgeons.

Each ambulance, for a brief and often critical period, is a mobile sickroom; but its occupants have no direct supervision by physicians or nurses. The ordinance and regulations are designed to standardize both ambulance operation and equipment in the city in order to provide a more sanitary and orderly service for litter cases and to insure competent attendants for the sick and injured.

Additional information regarding the ordinance and regulations may be obtained from John B. De Hoff, MD, director of local health services in the City Health Department, Telephone 752-2000, Extension 309.

Dr. H. Maceo Williams Retires

On July 14, H. Maceo Williams, MD, retired from duties as administrative health officer with the Baltimore City Health Department.

A dedicated public health official, Dr. Williams came to the City Health Department in 1939, when he was appointed the first administrative health officer of the then newly established Druid Health Center, at 1313 Druid Hill Avenue.

Through his leadership, working in the community with medical and other groups, Dr. Williams has made invaluable contributions not only to the health of the residents of his area but to all Baltimore. In 1950, as the needs became more evident, the Druid Health Center operations were enlarged when a new Druid Health District was designated with Dr. Williams as the Health Officer. In 1961, a new and modern health center was opened at 1515 West North Avenue.

As the administrator of health services in an area with many health problems, ranging from high infant mortality to lead paint poisoning, tuberculosis, and venereal diseases, Dr. Williams, with typical thoroughness, applied himself and his growing staff to the tasks at hand and helped achieve new health records for this inner section of the city. Polio and lead paint poisoning are no longer the problems that they were, and the current infant and maternal mortality is among the lowest the city has seen.

Dr. Williams was born in Baltimore in 1898 and received his early education in local public schools. He attended Howard University in Washington, DC, and obtained the AB degree in 1920 and the MD degree in 1923. From 1924 until 1938, Dr. Williams had a highly successful private practice, which he left to begin his career in the Health Department. Before his assignment to the Druid Health Center, Dr. Williams attended the Harvard School of Public Health and was awarded the MPH degree in 1939.

Dr. Williams has been a physician with the Baltimore Public Schools, a visiting lecturer at

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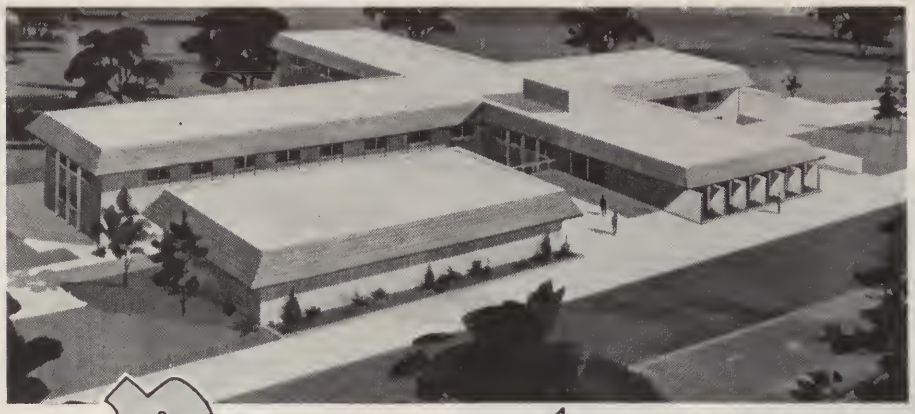
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Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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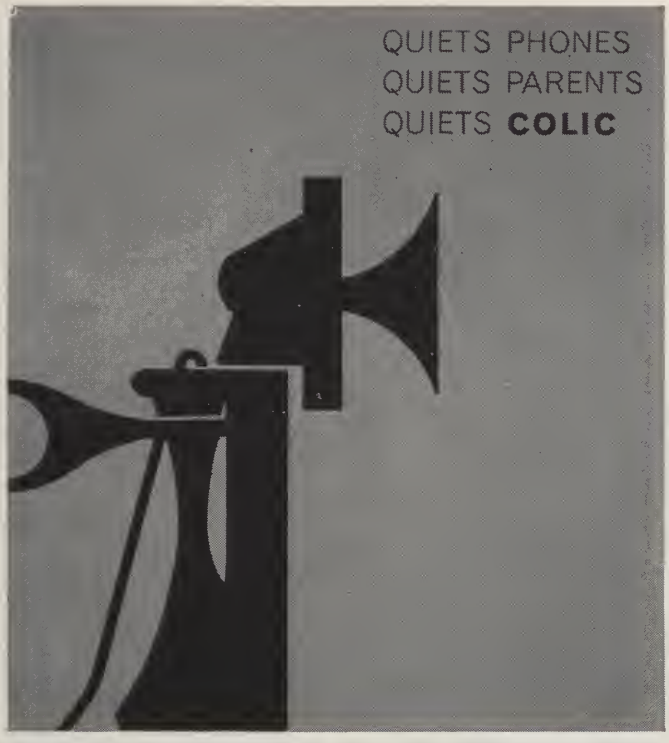
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Morgan State College, Howard University, and the Provident Hospital School of Nursing. As a member of the Board of Directors of the Maryland Tuberculosis Association, he helped direct the attack on what has frequently been called Baltimore's most serious public health problem. Dr. Williams is also a member of the American Trudeau Association, the Monumental City Medical Society, the National Medical Society, and the American Public Health Association. He is the author of a number of articles dealing chiefly with public health administration.

Robert E. Farber, MD
Commissioner of Health

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



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STATE OF MARYLAND

Department of Mental Hyqiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

Patient's Last Reported Diagnosis	Total	TYPE OF SUICIDE: Ingestion of Poison	Hanging	Gunshot Wound	Jumping From High Place	Other
Schizophrenia	19	2	4	7	5	1
Psychoneurotic disorders	22	9	3	6	—	4
Personality disturbances	9	1	2	4	1	1
Alcoholism	3	—	1	2	—	—
All others	6	2	—	1	—	3
Total	59	14	10	20	6	9
Total Maryland	399	73	57	191	9	69
Percent	14.8	19.2	17.5	10.5	66.7	13.0

SUICIDE

Fifteen per cent of all suicides in 1964 were committed by people currently or previously under care in a psychiatric hospital or outpatient facility. The 59 suicides among the 50,702 adults who had been under treatment in these facilities between July 1, 1961, and June 30, 1964, were equal to a rate of 116.4 per 100,000, as compared with a rate of 15.4 for the remainder of Maryland's adult population. While these figures indicate that suicides were proportionally nearly eight times as frequent among present or former patients, they also show that only a small number of these deaths occurred among these individuals.

The Table, based on data from the Maryland Psychiatric Case Register, shows the distribution of these suicides by type and by the patient's latest reported diagnosis. Most had psychoneurotic or personality disorders, while only a few had a diagnosis of alcoholism.

Thirteen deaths occurred while the patient was hospitalized. Five of these resulted from jumping from a high place and represented a majority of the nine deaths of this type recorded in the state. Of the remainder, 19 (32.2%) occurred while on hospital leave or under clinic care, and 27 (45.8%) after discharge from treatment.

Suicide has been described as a cry for help. It is often a conscious or subconscious indication of an inability or unwillingness to face and resolve the problems we feel are confronting us. Louis I. Dublin, in his book *The Facts of Life*, estimated that one out of every 70 American males and one out of every 220 females would ultimately commit suicide. Further, although the number of unsuccessful suicides is not known, it is believed that there are at least 10 suicidal attempts for every successful suicide.

Suicide has merited close attention and interest, since attempts at self-destruction could often be prevented and are a negation of our basic cultural

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DESOXYN® Gradumet® (methamphetamine hydrochloride)

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The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

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Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

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The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

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Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



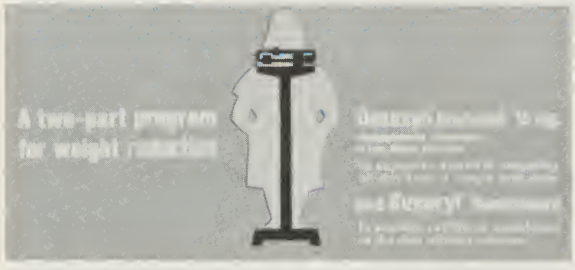
Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
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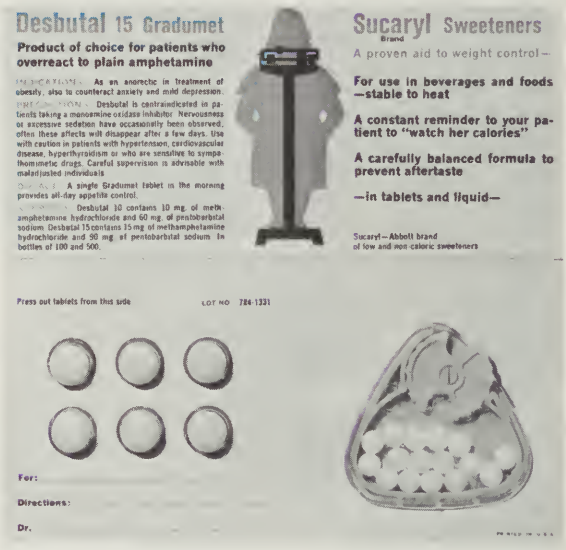


Front Side

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PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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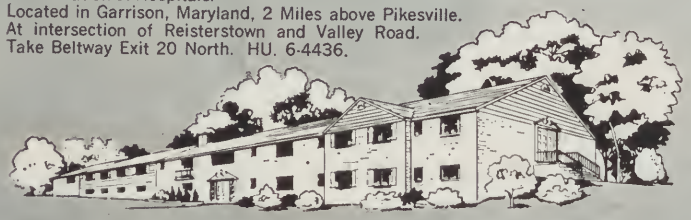


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and religious beliefs. One concrete result has been the establishment in some cities of special centers staffed by psychiatrists and other trained personnel where the would-be suicide can find professional help in meeting the problems confronting him. A facility of this type is now being sought in Baltimore. The development of comprehensive community mental health centers, by providing closer and more immediate mental health services, can also be expected to reduce the magnitude of this problem.

Kurt Gorwitz

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MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

BALTIMORE CHAPTER HOLDS DANCE

On June 24, the Baltimore chapter of the Maryland Association of Medical Assistants held a "Dance for Delegates" at the Gardenville Moose Lodge. The proceeds of the dance were contributed to the MAMA's fund to defray expenses of the Maryland delegate to the national convention in St. Louis in October.

At the regular monthly meeting of the Baltimore Association of Medical Assistants, held at Longley's Restaurant, Mr. James



TOP RIGHT: L-R: Dorothy Hartel, corresponding secretary, MAMA; Rita Cobry, president, BAMA; Marie Leiby; Ed Bury; William Leiby, treasurer, BAMA.

LOWER RIGHT: L-R: Margaret Krize; Dr. John Littleton, BAMA advisor; Mrs. John Littleton; Rita Cobry; Nell Chaney, president-elect, MAMA.

BELOW: L-R: Betty Fern, president, MAMA; John Komber, treasurer, MAMA, Mary Jane Komber.







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Debald of Smith, Kline, and French gave a most interesting presentation on "Drug Abuse."

Cumberland Chapter

The third educational seminar was held in Cumberland, at the Ali Ghan Shrine Country Club, on June 19. Featured speakers included Albert P. Marsh, MD, radiologist, who spoke on "Radioactive Isotopes," and Abdul S. Hashim, MD, pediatrician, who told about "Pediatrics in Iraq." Other subjects were: "Today's Court and Today's Medicine," by The Honorable F. Allan Weatherholt, and "One Girl for One Man," by Leslie R. Miles, MD, general practitioner.

Maryland Association of Medical Assistants

Newly-elected officers for the Maryland Association of Medical Assistants are:

Miss Betty Fern, president
Mrs. Nell Chaney, president-elect
Mrs. Gertrude Gillum, vice president
Mrs. Lottie Wolfson, secretary
Mr. John Komber, treasurer
Mrs. Dorothy Hartel, corresponding secretary

Committee chairmen are:
Frances Fairley, Membership
John Komber, Budget & Finance, Education
Nell Chaney, Constitution & Bylaws, Program
Peggy Bury, Publicity
Arlene Whelan, Public Relations
Ruby Taylor, Registration
Dorothy Hartel, Convention, Arrangements, Legislative
Shirlee Dubbs, Program Printing, Historian
Valerie Hachtel, Parliamentarian
Dorothy Walker, Civil Defense

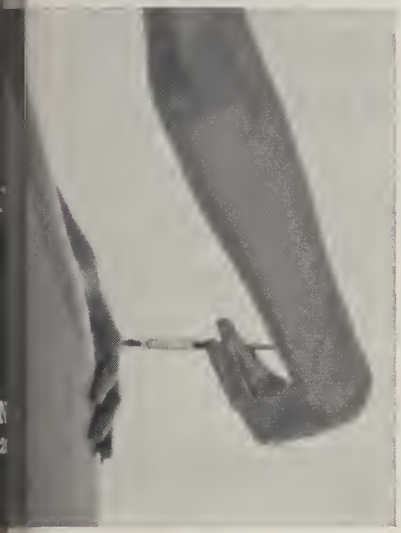
Peggy Bury

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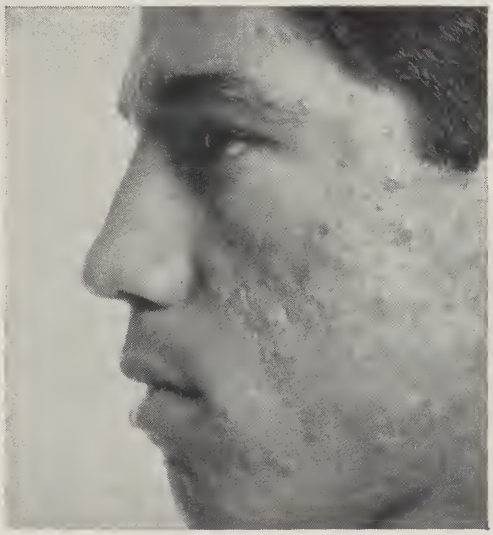
3. elderly or debilitated patients



patients with a past history of moniliasis



5. patients on long-term tetracycline or corticosteroid therapy



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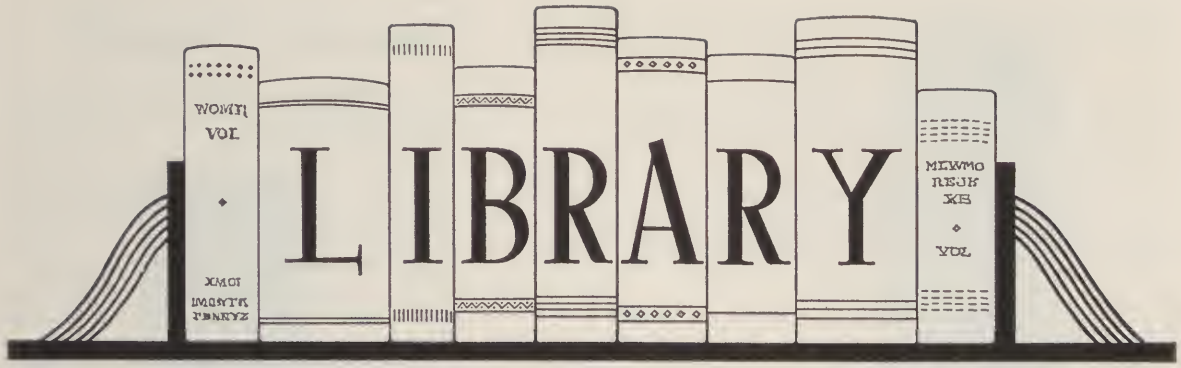
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Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
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Next month the Semiannual Meeting will be held in Ocean City. As before, a collection of recent books will be displayed for you to look at and charge out. If you would like us to bring specific titles or subjects, please notify the librarian beforehand so that we can satisfy your requests.

During June, the Medical Library Association met in Boston. Mr. Alfred Brandon, director, Welch Medical Library, Johns Hopkins Medical School, presided. Current problems and progress pertinent to medical libraries were discussed, including the Medical Library Assistance Act of 1965. At least a dozen medical librarians from the Baltimore area, including your librarian, attended this convention.

At the Medical Society Libraries Group dinner meeting, Dr. William Gordon, surgeon and member of the Board of Trustees, Denver Medical Society, and Mr. C. Lincoln Williston, executive director, Texas Medical Association, spoke on the library-physician relationships in the medical societies and the advantage of society-operated libraries, including the possibilities for increasing their services.

BOOK NOTES

Intensive family therapy; theoretical and practical aspects, edited by Ivan Baszormenyi-Nagy, MD, and James L. Framo, PhD, New York: Hoeber, 1965. 507 pages.

Fifteen authorities contributed original chapters to this publication, which will serve as a guide for practitioners now working through conjoint treatment of the whole family. It presents viewpoints of the various schools of intensive family therapy. Each chapter includes a good bibliography pertinent to the subject.

Family therapy; a selected annotated bibliography, published by The National Clearinghouse for Mental Health Information, a branch of the Public Health Service, presents a good review of the subject. It is limited to publications in the English language which would be readily available. While not comprehensive, it attempts to give a broad range of current practices.

The heart; its functions in health and disease, by Arthur Selser. University of California Press, 1966.

Cardiovascular diseases and care of the cardiac patient are subjects of growing concern, due to the fact that 14.6 million adult Americans have some form of heart disease. This book fills a need for those who need something at a higher level than the popular type publication yet not as technical as the books written for the physician. It could be read profitably by the patient at his doctor's suggestion. It is number 1 in the series, *Perspectives in Medicine,* edited by Leo van der Reis, MD.

RECENT ACCESSIONS

Histology

Bevelander, Gerrit: *Essentials of histology,* 5th ed, Mosby, 1965.

Voice

Greene, Margaret C.: *The voice and its disorders,* 2nd ed, Lippincott, 1964.

Bacteriology

Gillies, Robert Reid: *Bacteriology,* illustrated by R. R. Billies and T. C. Dodds; foreword by R. Cruickshank. Williams & Wilkins, 1965.

Mental Health Services

Furman, Sylvan S.: *Community mental health services in northern Europe: Great Britain, Netherlands, Denmark, and Sweden,* US Dept. Health, Education, and Welfare, Pub. Health Service, Nat. Inst. of Health,

Nat. Inst. of Mental Health; for sale by Supt. of Documents, US Govt. Print. Off. Washington, 1965.

Aneurysms, Intracranial

Pool, James Lawrence: *Aneurysms and arteriovenous anomalies of the brain: diagnosis and treatment,* Hoeber, 1965.

Family Psychotherapy

Boszormenyi-Nagy, Ivan (ed.): *Intensive family therapy: theoretical and practical aspects,* Hoeber, 1965.

Alcoholism

Block, Marvin A.: *Alcoholism, its facets and phases,* Day, 1965.

Heart Diseases

Selser, Arthur: *The heart, its function in health and disease,* U. of Calif. Press, 1966.

Fowler, Noble O: *Physical diagnosis of heart disease,* Macmillan, 1962.

Ciba Foundation Symposium: *cardiomyopathies,* London, 1964. Boston: Little Brown, 1964.

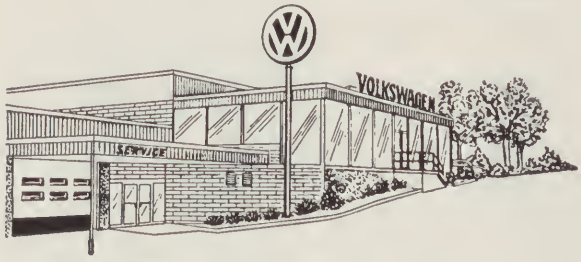
Surgery

White, Robert R. (ed): *Atlas of pediatric surgery,* Blakiston, 1965.

U. S. Army Medical Service: *Neurological surgery of trauma.* For sale by Supt. of Documents. U. S. Govt. Print. Off., 1965

Nursing Education

Anderson, Bernice E.: *Nursing education in community junior colleges,* Lippincott, 1966.



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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

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Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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BALTIMORE NEWSWRITERS WIN 1965



Faculty President J. Morris Reese, MD (right), presented a check for $1,000 to Mrs. Joann Rodgers and Mr. Louis Linley, winners of the AMA's 1965 Medical Journalism Award for newspapers.

—Photo by the Baltimore News American

MEDICAL JOURNALISM AWARDS

A series of articles in The Baltimore News American, written with the cooperation of the Medical and Chirurgical Faculty, won two medical journalism awards for newspapers. The writers, Mrs. Joann Rodgers and Mr. Louis Linley, of the News American staff, were awarded $1,000 from the AMA and $2,500 from the Albert and Mary Lasker Foundation.

Entitled "Your Health and Medicine," the 15-part series surveyed man's major diseases and physical disorders. The articles gave the historical background as well as the most current knowledge about the major killing and crippling diseases. The series ran three times a week for five weeks, between October 10 and November 9, 1965. Each article started on the front page and was continued with a double-page spread inside.

The Medical and Chirurgical Faculty recommended an expert in each of the areas to be surveyed. The consultants assisted the writers by providing information in their specialty and by checking the written drafts for medical accuracy. The Faculty also helped in securing permission to reprint illustrations from various sources.

The AMA cited the newspaper series as "an outstanding example of journalism that contributes to a better public understanding of medicine and health in the United States." The judges for the Albert Lasker Medical Journalism Award considered it one of the most extraordinary series ever to appear in the public press.

SUBJECTS AND CONSULTANTS FOR "YOUR HEALTH AND MEDICINE" NEWSPAPER SERIES

Oct 10, Heart: Hilary T. O'Herlihy, MD
Oct. 11, Cancer: John M. Dennis, MD, and Morris Wizenberg, MD
Oct 12, Arthritis and Rheumatism: Harry F. Klinefelter, MD
Oct 17, Allergy: Thomas E. VanMetre, Jr., MD
Oct 18, Eye: Richard D. Richards, MD
Oct 19, Venereal Disease: James E. Peterman, MD
Oct 24, Gastrointestinal Disorders: Samuel Morrison, MD
Oct 25, Diabetes: J. Sheldon Eastland, MD
Oct 26, Respiratory Diseases: Eugene J. Linberg, MD
Oct 31, Pregnancy: J. Morris Reese, MD
Nov 1, The Child: Wilson L. Grubb, MD, and J. L. Rhyne, MD
Nov 2, Pharmacology: John C. Krantz, Jr., PhD
Nov 7, Orthopedics: James B. Brooks, MD
Nov 8, Mental Illness: Robert W. Gibson, MD
Nov 9, Scope of Medicine Today: Manning W. Alden, MD, Wolcott L. Etienne, MD, and Mr. John Sargeant

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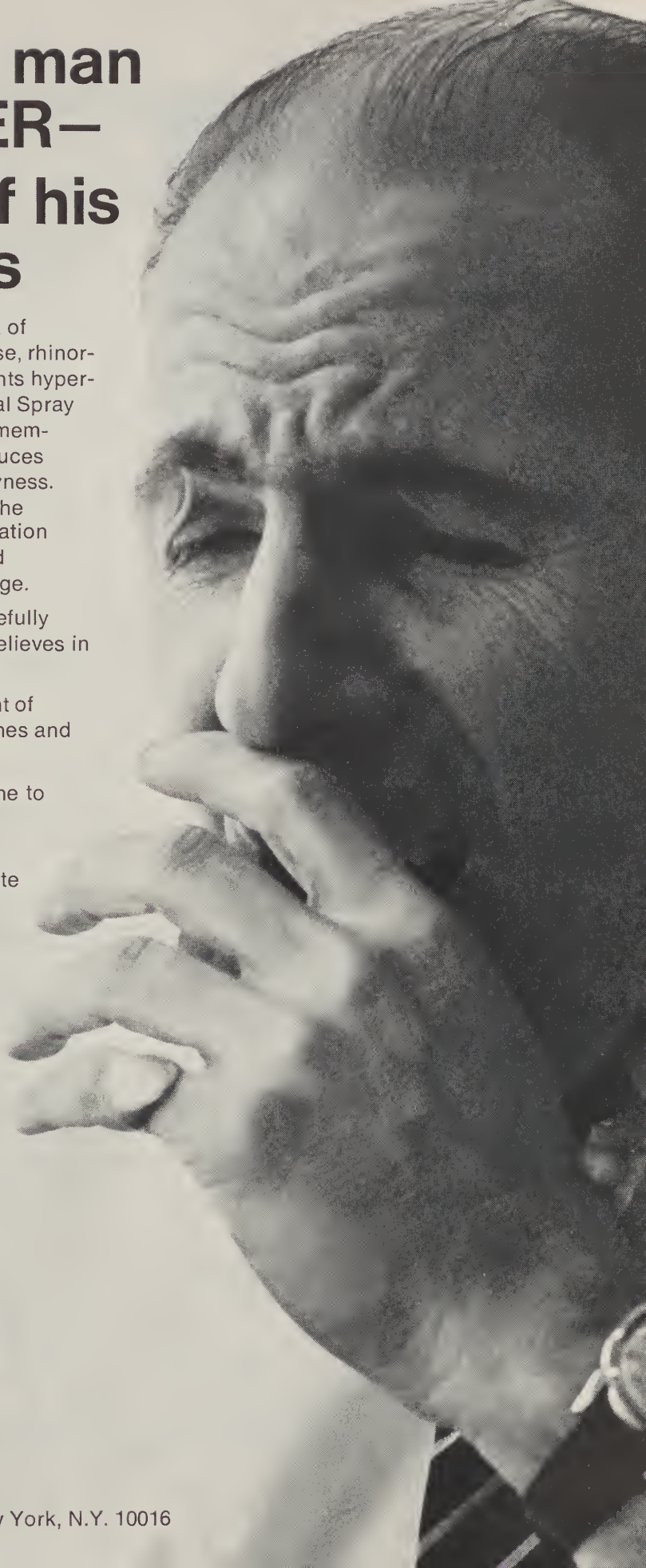
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A committee was formed after Dr. Goldstein's many friends spontaneously proposed the establishment of a memorial tribute. They cited his long and distinguished career at Sinai Hospital and Levindale, his leadership of the Medical and Chirurgical Faculty, and his life-long influence upon and contributions to his students and colleagues at the University of Maryland as a mark of his boundless energy and unlimited talents.

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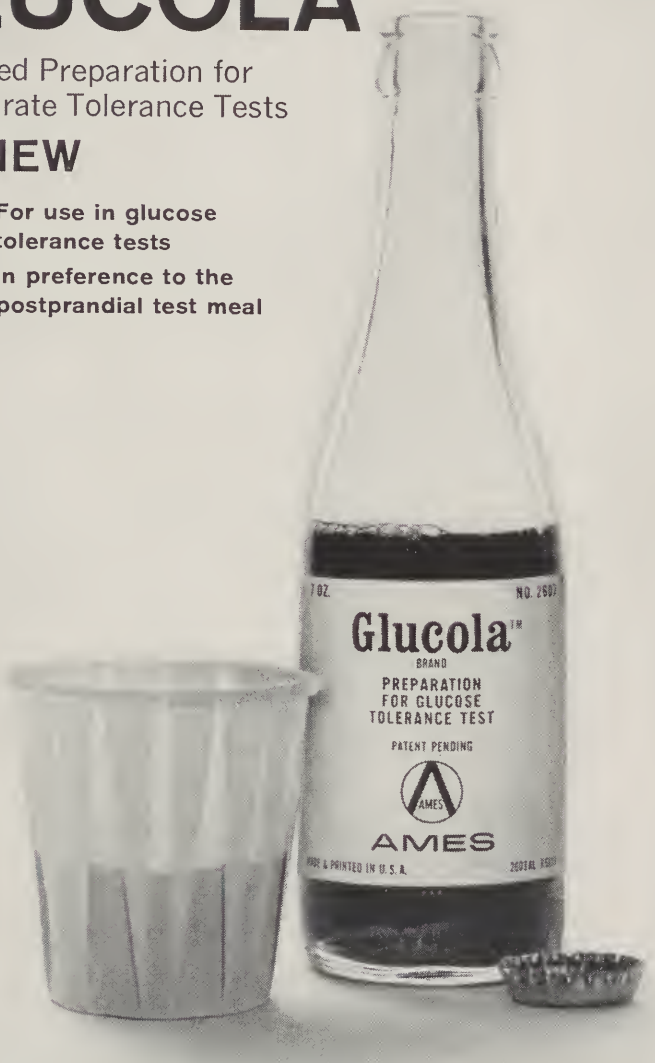
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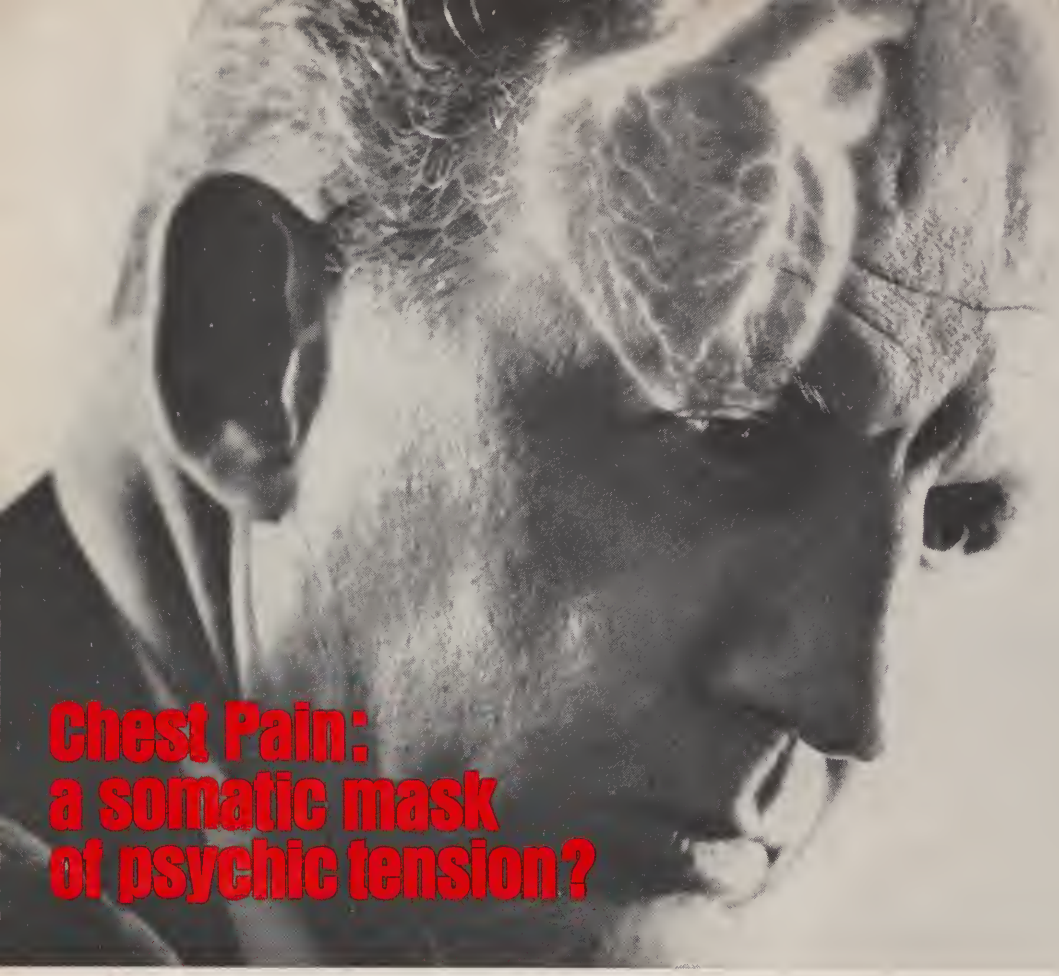
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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

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(1) Portnoy, J.; Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS. *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.: Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAB., *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.



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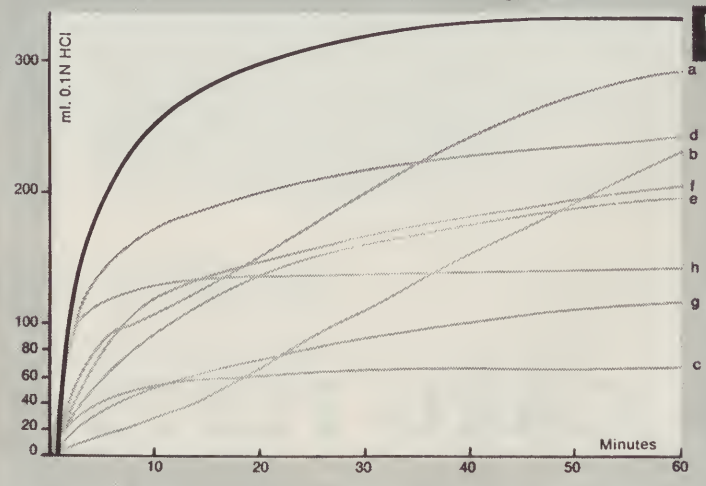
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In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

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Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

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Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

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For Hotel Reservations Contact: Convention Housing Bureau, Southern Medical Association, 1616 K Street, N.W., Washington, D. C. 20006

Doctors take note...

SEMINAR ON MEDICAL ASPECTS OF TRAFFIC SAFETY

Wednesday, October 12, 1966

Sheraton-Belvedere Hotel, Baltimore

Sponsored by the Medical and Chirurgical Faculty and the Maryland Chapter of the American College of Surgeons.

9:30 AM-12:30 PM

Welcoming message from Governor Tawes followed by discussions on The Role of Alcohol in Traffic Fatalities, Drugs and Driving, Medical Conditions and Driving Ability, and Legal Problems Involved in Development of Legislation.

12:30 PM—LUNCHEON

The gubernatorial candidates will give their viewpaints on the traffic safety problem in Maryland.

2 PM-4 PM

Workshop on the subjects discussed in the morning, following by a general summation.

MAKE YOUR RESERVATIONS BY CALLING FACULTY OFFICE: 539-0872

HEART ASSOCIATION OF MARYLAND

Annual Meeting

October 7-8 Washington Country Club, Gaithersburg

MARYLAND SOCIETY OF INTERNAL MEDICINE

JOINT MEETING WITH THE SECTION ON INTERNAL MEDICINE, BCMS

October 3, 8 PM

"The Role of Bacterial Endotoxin in the Pathogenesis of Fever."

Sheldon E. Greisman, MD, associate professor of medicine, University of Maryland School of Medicine.

BALTIMORE CITY MEDICAL SOCIETY

October 7, 8:30 PM

"Use and Misuse of the Newer Antibiotics"

Richard B. Hornick, MD associate professor of medicine and head, Division of Infectious Diseases, Department of Medicine, University of Maryland School of Medicine.

Acceptable for two hours Category I credit by the American Academy of General Practice.

"Summary of Maryland Medical Assistance Plan (Title XIX)"

William J. Peeples, MD, Commissioner of Health, State of Maryland Department of Health.

MARYLAND PSYCHIATRIC SOCIETY

October 13

"Brief Hospitalization"

Duncan McMillan, MD, superintendent, Mapperly Hospital, Nottingham, England.

PATHOLOGY SECTION, BCMS

October 17

1. Slide seminar moderated by **William Hartmann, MD**, Surgical Pathology Department, The Johns Hopkins Hospital.
2. "Amyloid Producing Tumors of the Thyroid," **William Hartmann, MD**

ARTHRITIS SYMPOSIUM

LAKE WRIGHT MOTOR HOTEL

October 7-8

sponsored by:

Tidewater Branch, the Arthritis Foundation

and the

Norfolk County Medical Society

For further information, write to the Arthritis Foundation, Tidewater Branch, 809 Brandon Ave, Room 306, Norfolk, Va 23517.

OBSTETRICS AND GYNECOLOGY COURSE

sponsored by

The Academy of Medicine of New Jersey

November 16-19

St. Barnabas Medical Center, Livingston, NJ

The course, presented in cooperation with the New Jersey Obstetrical and Gynecological Society and the New Jersey State Department of Health, will cover all aspects of obstetrics and gynecology from the juvenile to the geriatric patient. An outstanding faculty has been gathered for the three and one-half days.

Tuition will be $20 a day or $50 (including lunches and parking) for the entire three and one-half days. Arrangements will be made for overnight accommodations in a nearby motel.

AAGP credit has been applied for.

Further information can be obtained from James Breen, MD, chairman, Section on Obstetrics & Gynecology, The Academy of Medicine of New Jersey, 317 Belleville Avenue, Bloomfield, NJ 07003.

THIRD NATIONAL CONGRESS ON MEDICAL QUACKERY

sponsored by the American Medical Association and the National Health Council

October 7-8

PICK-CONGRESS HOTEL, CHICAGO

For program and registration form, write to John G. Thomsen, MD, chairman, Committee on Quackery, American Medical Assaciation, 535 N Dearborn St, Chicago, Ill 60610.

AMERICAN COLLEGE OF PHYSICIANS

Regional Meeting for Maryland and District of Columbia Internists

October 15

Auditorium of the District of Columbia Medical Society Headquarters Building, Washington, DC

For further information write to: Thomas W. Mattingly, MD, Washington Hospital Center, 110 Irving Street, NW, Washington, DC.

FELLOWSHIP TRAINING PROGRAMS

1. Comprehensive (Psychosomatic) Medicine for the Internist or General Practitioner.

Applications are being accepted for training in comprehensive (psychosomatic) medicine in the Departments of Medicine and Psychiatry at the Sinai Hospital of Baltimore, a 500-bed community general hospital, clasely affiliated with the Johns Hopkins Hospital and School of Medicine. The training program is based on a 34-bed medical ward service with clinical responsibility and close supervision by staff psychiatrists and internists. Training stipends paying $12,000 a year are available through the USPHS. Inquiries should be directed to Bernard P. Shochet, MD, Liaison Service, Sinai Hospital of Baltimore, Belvedere and Greenspring Avenues, Baltimore, 21215.

2. Psychiatry as it Applies to General Medical and Pediatric Practice.

A postgraduate training program for internists, general practitioners, and pediatricians has been developed at the University of Maryland School of Medicine. Trainees can spend fulltime for six months to a year in intensive training in the comprehensive clinical diagnosis, psychological evaluation and psychotherapy of medical or pediatric patients. Stipends are available which pay up to $12,000 a year.

For further information write to Virginia Huffer, MD, Department of Psychiatry, University of Maryland School of Medicine Baltimore, Md 21201.

MEDIC

1966-1967 SCHEDULE OF POSTGRADUATE PROGRAMS
presented through
Medical Education's Dedicated Instructional Channel

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MEDIC is a telephone network which joins the cooperating parties for the purpose of postgraduate education. It is hoped that by this means the listening audience for scientific programs now being presented in Maryland may be enlarged. It is provided through the cooperative efforts of:

- **The Medical and Chirurgical Faculty of the State of Maryland**
- **The Maryland State Department of Health**
- **The Hospital Council of Maryland, Inc.**
- **Participating hospitals.**

☆ ☆ ☆

APPROPRIATE CREDIT WILL BE GIVEN BY THE AMERICAN ACADEMY OF GENERAL PRACTICE FOR ATTENDANCE AT MEDIC LECTURES.

Programs are presented on Friday unless otherwise indicated.

PROGRAM LISTINGS WILL APPEAR MONTHLY IN THE MARYLAND STATE MEDICAL JOURNAL.

PROGRAMS

SEPTEMBER 30—12:30 PM

Treatment of the Unconscious Alcoholic: Immediate and Long Term

Julius R. Krevans, MD, Associate Professor of Medicine, The Johns Hopkins Hospital, and Head of Department of Medicine, Baltimore City Hospitals
and
Isadore Tuerk, MD, Commissioner, State Department of Mental Hygiene.

Sponsor: Subcommittee on Alcoholism: Medical and Chirurgical Faculty

OCTOBER 7—12:30 PM

Refractory Shock

Arlie R. Mansberger, Jr., MD, Associate Professor of Surgery, University of Maryland School of Medicine.

Sponsor: University Hospital

OCTOBER 14—12:30 PM

Backache

Martin L. Singewald, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

OCTOBER 21—12:30 PM

Selection of Patients for Cardiac Surgery

R Adams Cowley, MD, Professor and Head, Division of Thoracic Surgery, University of Maryland School of Medicine.

Sponsor: Peninsula General Hospital

OCTOBER 28—1 PM

Hypoglycemia

David Rabinowitz, MRCP, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: Frederick Memorial Hospital

NOVEMBER 4—12:30 PM

Organic Versus Functional Psychoses: Differential Diagnosis

Virginia Huffer, MD, Associate Professor of Psychiatry, University of Maryland School of Medicine
and
Lindbergh S. Sata, MD, Assistant Professor of Psychiatry, University of Maryland School of Medicine.

Sponsor: University Hospital

NOVEMBER 11—12:30 PM

Pediatric Surgical Emergencies

J. Alex Haller, Jr., MD, Associate Professor of Surgery, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

NOVEMBER 18—12:30 PM

Practical Dermatologic Diagnosis

Thomas W. Cooper, MD, Hagerstown.

Sponsor: Washington County Hospital

NOVEMBER 25—1 PM

Intersex Problems

Milton S. Grossman, MD, Assistant Professor of Pediatrics, University of Maryland School of Medicine.

Sponsor: Frederick Memorial Hospital

DECEMBER 2—12:30 PM

Treatment of the Female Climacteric

Arthur L. Haskins, MD, Professor and Head of the Department of Obstetrics and Gynecology, University of Maryland School of Medicine.

Sponsor: University Hospital

DECEMBER 9—12:30 PM

Peptic Ulcer

Theodore M. Bayless, MD, Instructor of Medicine, The Johns Hopkins University School of Medicine
and
Walter F. Ballinger, II, MD, Associate Professor of Surgery, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

DECEMBER 16—12:30 PM

Kidney Disease

Warren P. Gruppee, MD, Babies and Children's Hospital, Cleveland.

Sponsor: Cumberland Memorial Hospital

JANUARY 6—12:30 PM

Use of Drugs and Alcohol and Their Relation to Automobile Accidents

Russell S. Fisher, MD, Professor of Forensic Pathology, University of Maryland School of Medicine.
and
Henry C. Freimuth, MD, Associate Professor of Forensic Pathology, University of Maryland School of Medicine.

Sponsor: University Hospital

JANUARY 13—12:30 PM

Arteriosclerosis and Diet

Benjamin M. Baker, MD, Professor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

JANUARY 20—12:30 PM

Organ Scans

William A. Newman, MD, and **Albert P. Marsh, MD,** Radiology Department, Sacred Heart Hospital.

Sponsor: Sacred Heart Hospital

JANUARY 27—1 PM

Differential Diagnosis of Growth Retardation and Sexual Infantilism in Adolescence

Robert M. Blizzard, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.

Sponsor: Frederick Memorial Hospital

FEBRUARY 3—12:30 PM

Mental Retardation, Pseudo-Retardation and School Failure

Raymond L. Clemmens, MD, Associate Professor of Pediatrics, University of Maryland School of Medicine.

Sponsor: University Hospital

FEBRUARY 10—12:30 PM

Acute Head Injuries

Perry Black, MD, Instructor of Neurosurgery, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

FEBRUARY 17—12:30 PM

Clinical Studies of Diabetes

Thaddeus E. Prout, MD, Chief, Department of Medicine, Greater Baltimore Medical Center.

Sponsor: Greater Baltimore Medical Center

FEBRUARY 24—1 PM

Pineal Gland

Richard J. Wurtman, MD, National Institutes of Health, Bethesda.

Sponsor: Frederick Memorial Hospital

MARCH 3—12:30 PM

Anesthesiology-Respiratory Problems of the Asthmatic

Martin I. Gold, MD, Associate Professor of Anesthesiology, University of Maryland School of Medicine.

Sponsor: University Hospital

MARCH 10—12:30 PM

Hypersusceptibility to Infection: Evaluation and Management

F. Robert Fekety, Jr., MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

MARCH 17—12:30 PM

The Use of Physical Medical Techniques in the Management of Arthritis

B. Stanley Cohen, MD, Head, Department of Physical Medicine and Rehabilitation, Sinai Hospital of Baltimore.

Sponsor: Sinai Hospital

MARCH 24—1 PM

Parathyroid Disease

Commander Jonas Sode, MC, Medical Service, U. S. Naval Hospital, Bethesda.

Sponsor: Frederick Memorial Hospital

MARCH 31—12:30 PM

The Effective Use of a Pathology Service

Thomas M. Peery, MD, Professor of Pathology and Director of Laboratory Service, George Washington University Medical School.

Sponsor: Anne Arundel General Hospital

APRIL 7—12:30 PM

Open Heart Surgery—Preoperative Evaluation of Patients With Acquired Heart Disease

R Adams Cowley, MD, Professor and Head, Division of Thoracic Surgery, University of Maryland School of Medicine.

Sponsor: University Hospital

APRIL 14—12:30 PM

Population Dynamics

Paul A. Harper, MD, Professor of Maternal and Child Health and Population Dynamics, The Johns Hopkins University School of Hygiene.

Sponsor: The Johns Hopkins Hospital

APRIL 21—12:30 PM

Population Control

Hugh J. Davis, MD, Assistant Professor of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

APRIL 28—1 PM

Concepts in Treatment of Adrenocortical Dysfunction

Col. William Beisel, MC, Walter Reed Unit, Fort Detrick Army Hospital.

Sponsor: Frederick Memorial Hospital

MAY 5—12:30 PM

Use and Abuse of Psychotropic Agents

Gerald D. Klee, MD, Associate Professor of Psychiatry, University of Maryland School of Medicine
and
Walter Weintraub, MD, Associate Professor of Psychiatry and Director of Inpatient Service, University of Maryland School of Medicine and Hospital.

Sponsor: University Hospital

MAY 12—12:30 PM

Chemotherapy of Malignancy

Albert H. Owens, Jr., MD, Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: The Johns Hopkins Hospital

MAY 19—12:30 PM

Hypogonadism

Saul W. Rosen, MD, USPHS, National Institutes of Health, Bethesda.

Sponsor: Prince George's General Hospital

MAY 26—1 PM

Treatment of Thyrotoxicosis

J. Elliot Levi, MD, Instructor of Medicine, The Johns Hopkins University School of Medicine.

Sponsor: Frederick Memorial Hospital

CONTINUING PROGRAMS

TUESDAY EVENINGS—8 PM

Presentation and Discussion of Cases

Joint Anesthesia Study Commitee of the Baltimore City Medical Society and the Baltimore City Health Department

October 25, 1966
November 22, 1966
January 24, 1967
February 28, 1967
March 28, 1967
April 25, 1967
May 23, 1967

SATURDAY MORNINGS—8-9:30 AM

PEDIATRIC GRAND ROUNDS*
The Johns Hopkins Hospital

SATURDAY MORNINGS—10-11:30 AM

MEDICAL GRAND ROUNDS*
The Johns Hopkins Hospital

TUESDAY MORNINGS—11:30 AM

MEDICAL GRAND ROUNDS*
University Hospital

* Heard only at participating hospitals.

MEDIC programs may be heard presently at the following participating hospitals:

Anne Arundel General Hospital, Annapolis
Baltimore City Hospitals, Baltimore
Baltimore County General Hospital, Randallstown
Calvert County Hospital, Prince Frederick
Cambridge-Maryland Hospital, Cambridge
Carroll County General Hospital, Westminster
Cumberland Memorial Hospital, Cumberland
Easton Memorial Hospital, Easton
Eugene Leland Memorial Hospital, Riverdale
Frederick Memorial Hospital, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial Hospital, Havre de Grace
The Johns Hopkins Hospital, Baltimore
Kent & Queen Anne's Hospital, Chestertown
Lutheran Hospital, Baltimore
Montgomery General Hospital, Olney
North Charles General Hospital, Baltimore
Peninsula General Hospital, Salisbury
Physicians Memorial Hospital, La Plata
Prince George's General Hospital, Cheverly
Sacred Heart Hospital, Cumberland
St. Joseph Hospital, Towson
St. Mary's Hospital, Leonardtown
Sinai Hospital, Baltimore
Southern Maryland General Hospital, Clinton
University Hospital, Baltimore
Washington County Hospital, Hagerstown

AND AT THE FOLLOWING LOCATIONS

Medical and Chirurgical Faculty Building, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street
Baltimore, Maryland 21201
539-0872
or
Department of Continuing Medical Education
State Department of Health
301 W. Preston Street
Baltimore, Maryland 21201
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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

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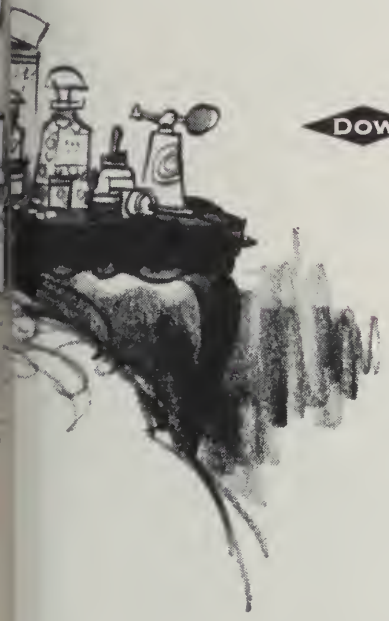
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Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

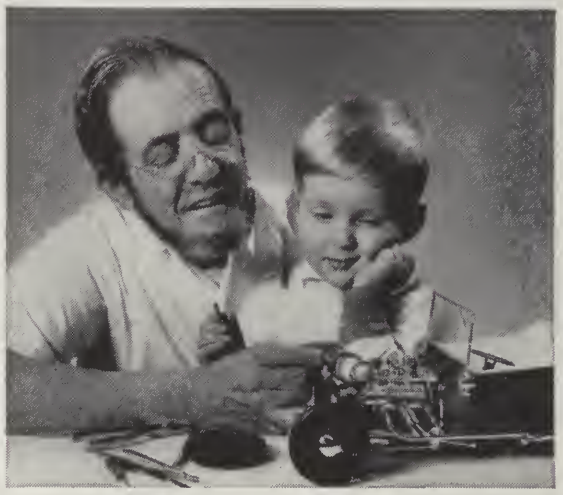
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

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References: **1.** Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. **2.** Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. **3.** Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. **4.** Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. **5.** Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. **6.** Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. **7.** Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. **8.** Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. **9.** Epstein, J. H.: Ibid 37:295 (Mar.) 1962. **10.** Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. **11.** Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. **12.** Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. **13.** Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. **14.** Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962.

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JOHN SARGEANT EXECUTIVE SECRETARY

Executive Committee, July 21

1. Information was received that the University of Maryland School of Medicine is conducting a survey to ascertain what general medical facilities are needed for the care of stroke patients.

2. Information was received that the Aetna Insurance Company will reverse its earlier policy and will make payments to hospitals for professional services rendered and billed through this medium.

3. Information was received that a representative from the U.S. Senate Subcommittee on Monopoly and Antitrust is seeking information on physicians who are "fronting" for lay laboratories, and those who have arrangements whereby they may profit from the services of these laboratories.

4. Legal counsel has advised that it is legal for a physician to accept a promissory note from a patient and give the patient a receipted bill in order for him to collect from the Medicare fiscal intermediary. Such promissory note should be included as a cash receipt for income tax purposes.

5. Authorization was granted for the payment of the expenses of the Faculty's arbitrators in the Crisfield Hospital dispute.

6. The Executive Secretary was authorized to make contacts in connection with selecting a *Journal* editor for recommendation to Council.

7. The Faculty will notify the Social Action Committee, Maryland Chapter, National Association of Social Workers, of its interest in and willingness to assist with activities pertaining to medical matters.

8. A communication was received from the Erie County, NY, Medical Society suggesting that contact be made with congressmen with recommendations for amending the law pertaining to Title XIX programs. No action is to be taken.

9. A letter is to be sent to the State Board of Health and Mental Hygiene and the State Department of Health, Education and Welfare expressing concern over the development of a Title XIX program in Maryland without consultation with the Advisory Council on Medical Care or the Faculty.

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Thursday . . . 9:30 A.M. to 8:30 P.M.



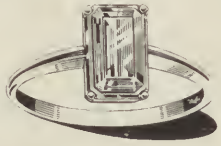
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EXECUTIVE SECRETARY'S NEWSLETTER

September, 1966

TRAFFIC SAFETY SEMINAR

Reminder: All-day Seminar on the Medical Aspects of Traffic Safety is scheduled for **Wednesday, October 12, 1966.** Programs are being sent to all members. Send your reservation in early.

MEDICAL ETHICS PROGRAM

An all-day session on Medical Ethics has also been scheduled for **Saturday, October 15,** at the Med-Chi Building. Primarily aimed at residents and interns who obtain very little of this during their student days, the sessions are open to all members.

Topics will range from "The Ethical, Legal and Moral Responsibilities" of physicians to a panel which will discuss "On Entering Practice."

More details to all members shortly.

DISPOSABLE HYPODERMIC NEEDLES

Complaints are being received in the Faculty office that some children are obtaining disposable hypodermic syringes from the trash receptacles which physicians have placed out for collection.

Physicians are urged to effectively destroy such syringes before placing them in the refuse so they may cause no harm through being an "attractive nuisance."

DRUG SAMPLES

Physicians are also advised to dispose of surplus drug samples by flushing them down the drain; or arranging for their pickup through the Woman's Auxiliary representative in their area. The Auxiliary has a project where surplus drugs are collected for eventual shipment to South Viet Nam and other areas throughout the world.

NEWS NOTES

Jacob H. Conn, M.D., has been elected North American Vice President in the Section of Clinical Hypnosis of the Pan American Medical Association.

New Fellows of the American College of Physicians include Samuel P. Scalia, Robert B. Rutherford, F. Fred Ruzicka, Sr., and Adam F. Szczypinski, all of Baltimore.

NEWS NOTES (cont'd)

Newly elected officers of the Maryland Tuberculosis Association are: William K. C. Morgan, President; David Marine, Vice-President; C. Murray Wylie, Secretary-Treasurer; Mary Ellen Avery and Milton B. Kress, both to the Executive Committee; and John E. Miller, local Councilor.

The Maryland Association of Private Practicing Psychiatrists include as officers: Theodore M. Feldberg, President; Michael J. Bisco, Vice-President; R. Taylor King, Secretary-Treasurer; and John G. Brickner and Dr. Feldberg as Counselors to the Maryland Psychiatric Society.

SCHOLARSHIPS IN MEDICINE

Ten State Senatorial Scholarships at the University of Maryland Medical School have been awarded to Maryland residents, the first since the recommendation of the Governor's Commission to Study the Shortage of GP's was adopted by the 1965 General Assembly.

One condition to the award is that the recipient must agree to serve for three years as a general practitioner in an area of medical need in this state.

DRUG ADDICTION REPORT AVAILABLE

The Maryland Commission to Study Problems of Drug Addiction's interim report includes a summarization of the drug abuse problem, Maryland's drug laws and a series of recommendations for a program to combat drug abuse. This report is available by request from Mr. Gerald Siegel, Chairman, Maryland Commission to Study Problems of Drug Addiction, Room 608, State Office Building, 301 W. Preston St., Baltimore, Maryland 21201.

PERSONALITIES

William H. Mosberg, Jr., M.D., Baltimore, has been designated as an official representative of the AMA to the All-Indian Medical Conference to be held in Dhanbad (Bihar), December 28 - 30, 1966.

John Sargeant

Executive Secretary

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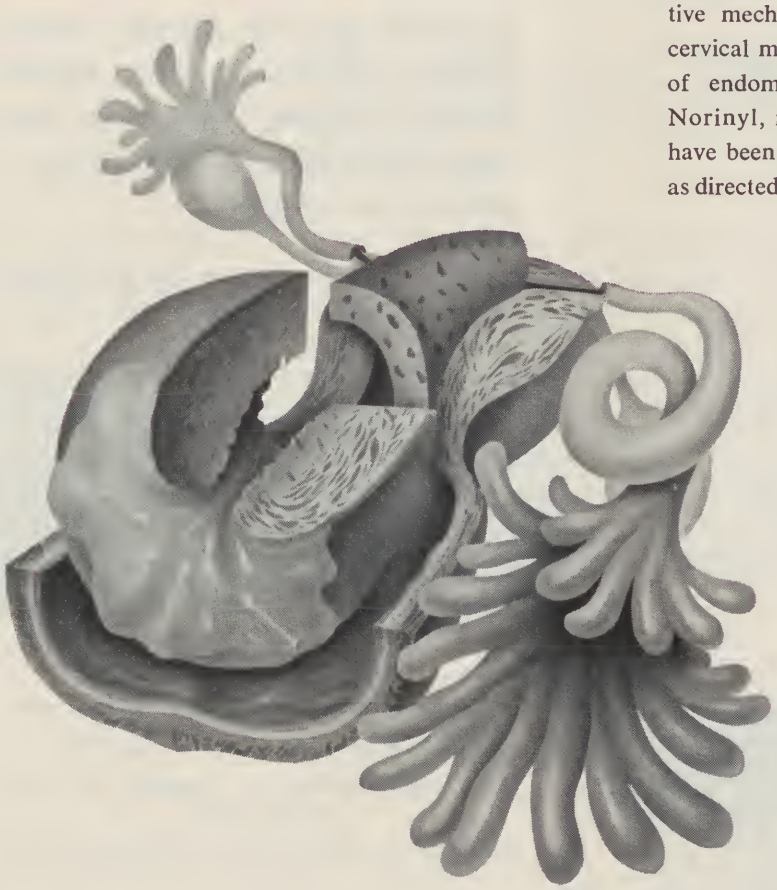
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Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

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An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

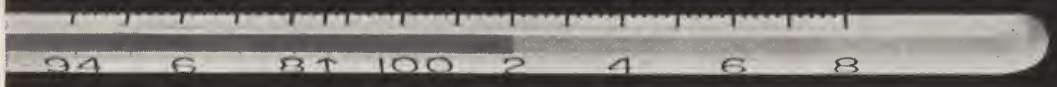
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DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

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Maryland State Medical Journal
Vol. 15, No. 9
September, 1966

Surgical Considerations in Gastrointestinal Bleeding

KARL F. MECH, MD
Assistant Professor of Surgery, University of Maryland School of Medicine; Chairman, Department of Surgery, St. Agnes Hospital

A myriad of conditions can cause major or minor bleeding from the gastrointestinal tract. Some are extremely serious, others relatively unimportant. Investigation of the patient's blood coagulating mechanism, proper diagnosis of site and cause of bleeding, and blood replacement before operation are of major importance. Good liaison between surgeon and medical man will pay dividends in many cases.

Appropriate surgery at opportune times will be indicated and often be lifesaving. The surgery for any particular portion of the gastrointestinal tract should be available whenever this condition exists. With good management, an acceptable surgical risk patient can be assured of good prognosis even in the face of life endangering bleeding. A plea is made for decision to operate before the blood is exhausted, patient debilitated, or other complications intervene. Choice of surgical procedure is discussed, and certain of these are recommended for specific conditions.

This presentation is in no way intended as a surgical discourse or treatise, but as an opportunity for me as a surgeon and you in the many branches of medicine to quietly discuss some matters of common interest. I feel no hesitation in taking up your time at this meeting to discuss this commonplace subject because of its frequency and importance and because it can be so elusive of diagnosis and so difficult to manage.

At the outset, I would like to state that no distinction can be made between "medical" or "surgical" gastrointestinal tract bleeding, and hospital admissions are properly made on either service. I hope to point out the value in many instances of joint management or at least consultative care by both medical man and surgeon.

I shall not argue the semantics of bleeding versus hemorrhage. The dramatic occurrence of the vomiting of blood or of the grossly bloody

Presented April 30, 1966, at the Bermuda Cruise Convention of the Medical and Chirurgical Faculty of the State of Maryland.

stool or tarry stool demands immediate attention. On the other hand, it must be conceded that often the microscopic or chemically detected melena may be even more important in early diagnosis and treatment of a still operable and curable malignancy, such as an ampullary carcinoma or a nonobstructive tumor of the bowel. Unexplained anemia may be the only clinical evidence of a carcinoma of the cecum, and proper investigation of this slow bleeding may lead to the important diagnosis.

The discovery of gastrointestinal tract bleeding does not necessarily dictate surgical intervention. Proper evaluation of the condition by the therapy team may indicate the wisdom of careful nonoperative management or early or delayed surgery. Much can be gained by adding the diagnostic acumen and treatment regimen of the medical therapist to that of the surgeon.

Diagnosis is of prime importance. The frustration and chagrin of the surgeon who conducts a surgical exploration of the gastrointestinal tract that is the site of massive hemorrhage without finding the site or cause, is known only to those of us caught in this predicament. Some authorities cite a figure as high as 20% for these frustrating cases even when the bleeding is known to be above the ligament of Treitz.

Nothing is more profoundly distressing to the surgeon than failure of the coagulation mechanism in a patient with gastrointestinal tract bleeding. Every effort must be made by history and first examination of the bleeding patient to determine that the platelet count, liver function, prothrombin time, and other factors in his coagulation mechanism are normal. In these investigations the knowledge of the hematologist, internist, or medical practitioner may save the patient and the surgeon needless or dangerous surgery. I want to stress again the infinite help given by a careful history if this is available from patient or family. Discovery of any one of numerous medical or hematologic conditions producing hemorrhage may relegate the case immediately to a nonoperative category.

The next major concern is to determine as accurately and quickly as possible the site and source of the bleeding. Investigation of this is carried out while the patient is being supported by fluids and blood transfusions. Dr. John Stewart, of the University of Buffalo, and many others have developed elaborate programs for studying serious gastrointestinal bleeders with blood volume determinations, esophagoscopy, emergency gastrointestinal series, radioisotope tagging of cells, and miscellaneous other tests. Some simple but valuable aids, such as the passage of a simple nasogastric tube, may help establish the level of bleeding. The Saenstaken-Blakemore tube may be used to advantage.

The esophagus is a most interesting organ, which frequently is the site of bleeding. The subject of carcinoma with penetration and perforation of a major thoracic vessel is too great to be elaborated here. The diagnosis is often obvious or already known to the patient and doctor from previous studies of dysphagia. Such hemorrhages are all too often lethal before anything can be done.

The tremendous exsanguinating hemorrhages of ruptured varices resulting from portal hypertension are sad but frequent occurrences. I have the impression that with the increase in alcoholism we are witnessing, the incidence of this dreadful consequence is on the increase. The immediate control of bleeding from the ruptured varices by the use of the Saenstaken-Blakemore tube is a lifesaving measure. In most case, however, this is only a temporary expedient, and some more definitive measure must be taken to alleviate the portal hypertension that is the background for the bleeding.

Numerous operations such as the ligation of the varices, partial gastrectomy, transsection of the stomach have had their day. The results of these procedures are so poor that it has been determined that the only effective treatment is a direct attack on the portal venous system. The services of a general surgeon or a vascular surgeon familiar with these procedures are essential. The recommended routine is to control the hemorrhage with the Saenstaken-Blakemore tube, which allows some hours to replace the blood volume by transfusion and fluids, digitalize if necessary, and otherwise prepare for an urgent or emergent surgical procedure. The choice of splenorenal or portocaval shunt lies with the operating surgeon. Most authorities prefer a routine portocaval shunt, that is anastomosis of portal vein to inferior vena cava. While the morbidity and mortality are still disap-

pointingly high, the results are much better than with any other form of management. Results improve with experience, choice of procedure, and general management, so this is the recommended course, aggressive as it may seem.

Ulceration in the pouch of a diaphragmatic hernia may be the source of severe bleeding. The technical control of this at operation may be difficult, but this is the procedure of choice since recurrent hemorrhage is very likely.

In the Mallory-Weiss syndrome, bleeding follows severe retching and vomiting, although this does not often demand surgical intervention.

The stomach often is the site of massive hemorrhage. Vomiting of large clots of blood after a period of nausea points to bleeding from this source. Emergency x-rays of the gastrointestinal tract may point out the diagnosis, although the presence of clots may make interpretation difficult.

Benign conditions such as aspirin ingestion, inflammation, telangiectases, benign tumors, or gastritis may cause bleeding and occasionally demand urgent surgical care, although many of these can be handled without operation or be corrected later.

Peptic ulceration of the stomach is the most frequent cause of massive hemorrhage. Without biopsy, differentiation from cancer may be difficult. Polypoid carcinoma or massive infiltrative cancers may bleed, but this is much less frequent than peptic ulceration.

In bleeding from the stomach and duodenum, a number of factors must be considered. Age of patient, severity of hemorrhage, availability of blood, odd blood types, or the general condition of the patient may dictate early surgical intervention rather than persist too long with cold lavage, small transfusions, and general support in the face of continuing hemorrhage. It is sad to be called upon to perform major surgery on a patient almost in extremis, with scarce blood replacement almost exhausted, with blood matching difficulties, with continuing hemorrhage. Mortality and morbidity increase alarmingly in such cases.

Acute or severe chronic hypertrophic gastritis may cause bleeding but often do not require operation.

The most frequent cause of gastrointestinal tract bleeding demanding surgical intervention is peptic ulceration of the duodenum. The tremendous frequency of this ailment accounts for this complication. History and physical examination, vomiting of clots, bright blood in the nasogastric tube, and emergency x-rays often make the diagnosis evident. In the young patient, active conservative care may control the emergency without surgery; however, in many cases, active consultation between medical man and surgeon will bring the case to corrective surgery before the ridiculous level of 15 to 20 pints of blood transfusions has been reached.

The choice of operative procedure varies with the surgeon, with proper consideration of history, age, general condition, and associated conditions. At surgery, the stomach and duodenum are opened and the abnormality verified. It is essential that the bleeding vessel be controlled by transfixing it with a nonabsorbable suture, usually silk, but more must be done to prevent recurrence of the bleeding. The time-honored procedure of subtotal gastric resection is still valuable and reliable, and the older surgeons still lean toward this. The trend today, however, is to ligate the bleeding vessel and then perform a drainage operation, such as a pyloroplasty, using the gastroduodenotomy incision, and performing a vagus nerve section at the same time. This affords definitive treatment of the ulcer diathesis while avoiding the longer operation for the patient whose condition is precarious and also avoiding the infrequent but annoying sequelae of gastrectomy.

The gastric freezing procedures have had only limited acceptance by the surgical specialists, so these will not be discussed.

I cannot pass over this region without mentioning an infrequent but interesting entity: carcinoma of the ampulla of Vater. The presence of occult blood in the stool and a faint tinge of jaundice may give away the diagnosis. The extensive operation of pancreaticoduodenectomy (the Whipple procedure) has been effective in salvaging a fair number of these patients.

Benign tumors and diverticuli rarely produce bleeding.

Bleeding from the jejunoileum is not a common finding, but when it does occur, it may be severe and dramatic. In children, especially, a most frequent cause of severe rectal bleeding is bleeding from a Meckel's diverticulum. This may be of life-endangering proportions and require emer-

gency surgery with removal of the diverticulum by resection. Diverticuli, polyps, leiomyomas, benign ulceration, or the very rare malignancy may cause gastrointestinal hemorrhage and should receive appropriate treatment.

A source of occult bleeding rather than major hemorrhage, yet causing severe anemia, often obscure and overlooked for months, is carcinoma of the cecum. These large growths rarely obstruct and so may grow large and bleed for a long time before they are detected. A high degree of suspicion and careful x-ray inspection of the cecum will help diagnose these so appropriate surgery can be performed. In this condition, the terminal ileum, cecum, ascending colon, and transverse colon to the middle colic artery, together with the mesocolon, are removed. A worthwhile salvage is obtained in many cases.

Benign growths of the large bowel often cause bleeding and should be diagnosed and treated. Lipomas may occasionally do this, but the most frequent are polyps, both benign and malignant, occurring throughout the colon. Bleeding sometimes is profuse. Sigmoidoscopy, barium enema, and air contrast enema usually confirm this diagnosis. Any of these polyps may be malignant, so all should be removed surgically with subtotal colectomy often indicated. If the bleeding is severe or protracted, we may be forced to explore without knowledge of the exact location of the bleeding point. Visualization of the bowel lumen during operation by means of the sterile sigmoidoscope may help to reveal the bleeding polyp and perhaps other polyps not otherwise suspected.

Another frequent cause of rectal bleeding, occasionally in large amounts, is diverticulitis. This condition can produce a considerable hemorrhage, often without recurrence; or bleeding may recur in some cases. Symptomatic cases may require resection for final cure.

The most frequent and urgently important lesion causing severe recurrent bleeding from the colon is carcinoma. In the transverse descending and sigmoid colon, the napkin-ring type of annular constricting carcinoma will bleed many times long before the ultimate intestinal obstruction occurs. Therefore, all cases of bright bleeding, brisk or of small volume, demand thorough investigation and early surgical intervention. Appropriate wide resection of bowel and mesocolon so as to insure removal of all lymphatics gives a fine prognosis in many of these cases. Delay in surgery due to patient neglect to report rectal bleeding, or delay by the physician for any reason past a short interval, is inexcusable in this enlightened day.

The medical conditions of the large bowel, comprising the colitis group, are usually well managed with diet, medication, including the corticosteroids, reassurance, and mental help. Occasionally one sees the fulminating case with 18-30 grossly bloody stools per day. Unless surgery is done relatively early, one is likely to find himself with a severely depleted patient in precarious general condition requiring massive emergency surgery. Early ileostomy with wide resection is necessary in these cases.

Rectal carcinoma is one of the most frequent sources of bright blood from the rectum. Nearly all of these cases can be diagnosed by a simple digital rectal examination. It is absolutely inexcusable to fail to do this examination routinely. Biopsy by sigmoidoscope makes the diagnosis certain. While some surgeons have performed low anterior resection, the principles of en bloc resection with blood and lymphatic drainage resection requires abdominoperineal resection. Results in the operable cases are surprisingly good.

A word must be said here about the lowly hemorrhoids. This condition is the sole cause of bleeding at the rectum in many cases, so the patient may have an unwarranted reassurance sometimes bolstered by the opinion of a physician without adequate examination. We err too often on the side of inadequate examination when hemorrhoids are visible and palpable. My plea is for complete examination to rule out other causes of bleeding at the rectum before accepting the hemorrhoids as the sole cause. When no other conditions are found, a well performed hemorrhoidectomy will correct matters easily.

11 East Chase Street
Baltimore, Md. 21202

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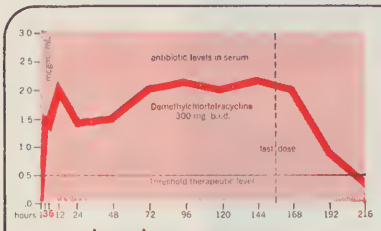
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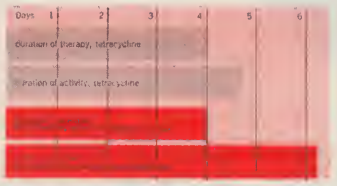
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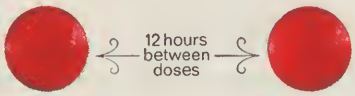
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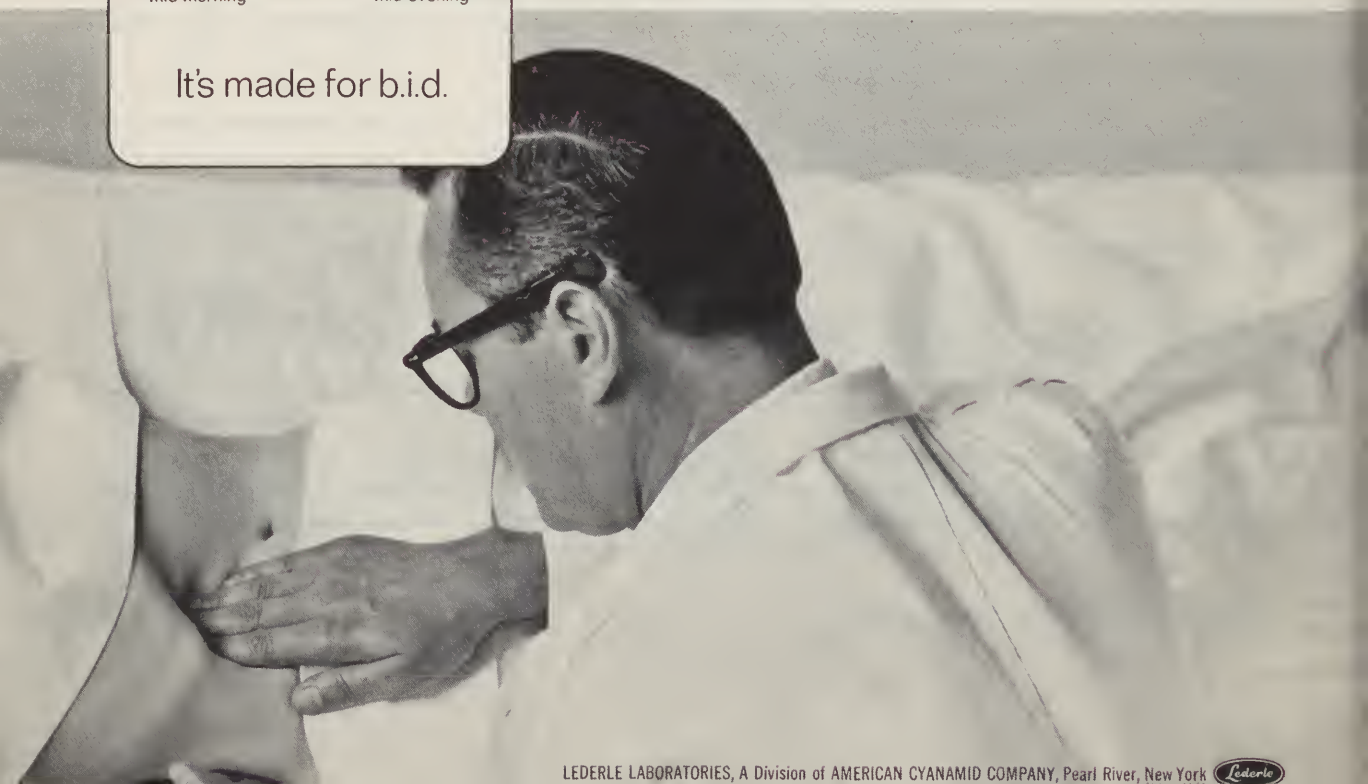
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No one is called upon more often to help in marital problems than the physician, particularly if there is a problem in sexual adjustment. Our esteemed position of healer and confidant and our knowledge of the human body, its functions and frustrations, lead our patients to expect assistance from us. Yet our medical education generally has not prepared us well to fit this particular role, and frequently our own bias and sensitivities make such counseling difficult if not painful.

Some ideas of how the average physician might help his patients are presented, along with advice about pitfalls to avoid.

Jonas R. Rappeport, MD

SEX IN MARRIAGE COUNSELING

Recently the medical profession has shown a strong interest in sex! That is, from a scientific and professional standpoint. It seems a little embarrassing, however, when we realize that only two or three medical schools in the country, even today, actually offer courses in sex. One of the reasons that there have not been courses in sex previously is that a thorough knowledge of the subject was not available, at least not in scientific form. All of us have had to learn the hard way, by personal experience. Unfortunately, this is a dangerous way to learn about sex, particularly if we try to apply it to our patients. If we use our personal experiences and feelings as a foundation for giving supposedly scientific clinical advice, we are going to run into trouble, and that is exactly what happens.

We devote a tremendous amount of research time to the most minute factors in illness and work diligently in the area of preventive medicine. But we have treated sex as if we, the medical profession, were all a bunch of virginal old maids. We have been following social custom instead of leading medical knowledge. Now we are way behind. Whether we like it or not, there have been and are terrific social upheavals in our culture, and a main area of such change is within the area of sexual behavior. These changes may be alien to our own personal standards, but we must accept what our patients regard as proper behavior.

Twenty or thirty years ago, I doubt if the average gynecologic patient would give an honest answer to her doctor, even if he dared to ask her about her sexual adjustment. The urologists, gynecologists, and other practitioners are being consulted more frequently today by patients with problems of sexual adjustment. Are we prepared to help any of these patients? I suspect that many of us aren't, and those who are, have tools which are of limited effectiveness. Nevertheless, we must use what we have. Havelock Ellis and Richard von Krafft-Ebing were followed by Sigmund Freud, whose understanding of infantile sexuality did a great deal to bring us out of the

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hinterlands. The fact that much of what Freud discovered was misunderstood and at times misapplied was probably due to our not being quite ready for it. Today, the work of Lorenz and Scott on animals, and Ford, Beach, Mead, Lloyd, Masters, Winokur, Lief, and countless others on human sexual behavior have opened up the scientific arena to a fuller understanding of this basic biological drive. Now we are more ready to understand, and we are gaining more knowledge of the physiology, psychology, and sociology of sex.

Today, I shall try to limit my comments to the general area of sex in marriage counseling and shall try to frame my comments within the context of those situations with which most physicians might come into contact. I shall avoid discussing entirely the physiology of sexual behavior but shall focus on the psychological aspects.

Sexual behavior would appear to be the result of the learning of group or culture specific patterns. Every society that has been studied seems to have its own specific sexual behavior codes, which generally serve as a part of the overall social and moral code of the community. We are so used to our own forms of behavior that we tend to define them as "the natural or God-given way." Beach reports that in New Guinea the female inferior position of intercourse is called "the missionary position." Among a particular Australian native group, when a virginal daughter is about to get married, the father calls on his best friend to introduce his daughter into the art of sexual behavior; and the best friend's wife performs the same function for the bridegroom. In some other cultures, adolescent heterosexual activity is encouraged, and upon entering marriage, each partner is well experienced. After marriage, however, no infidelity is allowed, and severe punishment is extracted if caught. Eskimo husbands, on the other hand, graciously loan their wives to visitors.

In the United States, we find different standards of sexual behavior in different socioeconomic classes, as well as in persons with different ethnic and religious backgrounds. It is difficult for middle class people to understand the behavior of the lower class male, and even more difficult for the female to understand comparable behavior. The lower class male is much more sexually experienced at marriage, considers masturbation unnatural, and is generally unconcerned about the female's sexual needs or pleasures. Preplay is of little interest to him, his own satisfaction being his primary concern. In contrast is the American middle class male, who may be more or less inexperienced at marriage, who has used masturbation as a release for years, and who enjoys preplay and considers himself a failure if his wife doesn't have an orgasm. Coupled with the male's feelings are the respective desires of the female, according to her upbringing.

One can readily see the problems that might arise if a physician attempts to counsel patients only from his own experience without some thought to and respect for the patient's own standards. Imagine the problems that a couple might have on coming from different cultures with varied expectations, desires, and limitations. Hence, the first and perhaps most important step in the evaluation of a marital sexual problem is a thorough and adequate history with particular emphasis on the sociocultural and religious background of the couple and how this affects their sexual practices.

A word of caution is indicated here. With our current emphasis on sex, people frequently present their problem in sexual terms when it really isn't sex at all which is the problem. A woman may complain about her husband's lack of sexual interest in her when the truth is that he finds it hard to get interested in her because she is a "bug" on cleanliness, never comes to bed on time because she is still housecleaning, and makes him take a shower and shave before she'll have intercourse although he likes to go to bed unshaven. Or the man complains that his wife is not interested in sex, when the truth is that the only time he is interested is when he is "drunk as a skunk," and that is most of the time. These are not mainly sexual difficulties. Nevertheless, they were presented as such, and they are problems of marital discord which require counseling. Whether a given physician will want to become involved in trying to counsel such couples or not will, of course, depend on his time, personal inclination, etc. Some of us are particularly astute and sensitive to such situations and can do an excellent job. Others prefer not to become involved, actually aren't comfortable in such situations, and are better off referring such patients to the various church or community agencies or

to a psychiatrist, psychologist, or marriage counselor.

Do you look at your patients when you ask about their sexual adjustment, or do you look away? Do you ask a negative question "You don't have any problems in your sexual life, do you?" If you do these things, then you aren't the one to do sexual counseling. You had best examine your feelings before you try. However, in the area of true sexual difficulties, there is no one who can adequately replace the physician as the proper person to help the couple.

Probably the most common problem brought to the physician is not impotence or frigidity but a less serious difficulty. The most common is probably one which I call sexual incompatibility. Fortunately, boys and girls are different in more ways than simple anatomy. Males are more generally aroused by psychological factors, such as jokes, stories, pictures, or observation of the partially clad or nude body. Females, however, seem generally to have little response to such stimuli. Instead, they respond more to "love talk" and actual physical contact, and then only when their mind is free from worry or fatigue. Many men cannot conceive of this and feel hurt or angry when their wives do not respond to the same things which stimulate them. A factual discussion of this by the physician will frequently soothe ruffled feathers.

The variation in basic sexual tension between couples, when misunderstood, can frequently lead to feelings of rejection and eventually to hostilities. Generally, the male has a higher and more constant sexual tension than the female, whose tension is more variable. Each couple has to attempt to work this out according to their individual needs. To call one partner "oversexed" and the other "undersexed" is just name-calling. If the personalities are reasonably mature, they can make a mutual adjustment with help.

Women often fear being the aggressor in sexual activities, even though at times they have the urge to. Frequently they have gotten the message that their husband can't accept this. Many males, however, would like to be fairly passive on occasion, and such temporary role reversals can lead to extremely pleasurable experiences. The physician can perform a great service by helping a couple increase their communication about their sexual desires and needs.

The sociologists tell us we are a matriarchal society. Passive-dependent, sexually inadequate males pose a real therapeutic problem. Such a man has been so inculcated in the cult of mommism that he is afraid to be aggressive in bed. He always waits for his wife to make the overtures, his feelings are easily hurt, he is partially impotent at times, or has premature ejaculations. Thus, he handles his hostility, fear, and frustration. Many such men require psychotherapy, but some can be helped by encouraging them to be more aggressive in bed and particularly by joint counseling in company with their wives, if the latter are not overwhelming. I shall speak of this type of counseling in a moment.

Many women complain of their husbands in such a way as to make us immediately suspicious of the situation. Their numerous petty complaints usually point out the fact that no matter what he does, he has to be no good. The man, of course, can do the same. Almost invariably, the history will reveal the father or mother, in the respective case, as being a person the patient hates. Father was no good, so husband is no good. Usually sexual problems are also thrown in.

I am not advocating infidelity; yet, as we know, it does happen. When it does occur, people are hurt. It is always important, when infidelity has been discovered, to attempt to find out why it occurred and why it was allowed to be discovered. A note of caution here: when a patient tells you about being unfaithful, never advise him, or her, to tell the spouse if she doesn't know. If he feels he must, point out to him that he is doing it more to relieve his own guilt and possibly to hurt his partner rather than to help her. It can't possibly help her. The same immature, selfish motives go into telling as went into acting.

Whenever possible, in working with the less serious sexual problems, which I have mentioned so far, it is axiomatic to try to work with both partners. The technique most counselors use consists of, first, seeing the original complainant, then the spouse, and then both together, if at all possible. Because we are dealing with problems of interaction, we can usually get a clear picture in the shortest possible time in this way. Clear, frank discussions are most useful, and the goal should always be toward trying to increase the couple's communication between each other so that they can continue the work in your absence. It

is surprising how many couples will not tell each other what they like or dislike about the other's sexual behavior.

Generally speaking, sexual jokes are taboo in such counseling. Without being priggish, it is important for the patient to know that you are being warmly concerned, yet a scientific helper, not a wise guy. I know that many physicians don't have time to spend like this. We just have to do the best we can or refer the patient to someone else. Many patients don't mind paying more for the extra time when its need is explained to them.

In his excellent book *Counseling in Marital and Sexual Problems,* Dr. Richard Klemer makes some practical suggestions. During the individual interviews, he frequently asks each partner, "What would he say about you if he were sitting here?" and, "If you could have any solution you desire, what would you like?"

Axiomatic in such "family" or "couple" counseling is to let the partners talk as much as possible. The doctor is there to answer specific questions AFTER he knows what each partner thinks about the question. By allowing each person to express his ideas and feelings, you then know what is misunderstood and can apply your knowledge directly. Care should always be taken to avoid accusing one partner or the other of "bad" things. Instead, one might wonder, "If Fred feels that he is being entirely fair to Mary." This arouses less anger than the direct statement, "You aren't being fair." Direct advice sometimes is necessary, however, along with facts about anatomy and physiology, preferably given as suggestions rather than prescriptions. To tell a reluctant man to rub his wife's clitoris before intercourse, or her to manipulate his penis might produce good mechanical results but with little feelings. It is better to wonder if such has ever been done by them, and if not, why not. ("How come you haven't?") After everyone understands the aversions or resistances, it may not even be necessary to make a direct prescription. Whenever we ask, "Have you ever done such and such?" we are actually making a suggestion.

Masters and Johnson in St. Louis, have done a great deal of investigation in human sexual behavior. I have only read reviews of their latest book, but it seems to represent the most thorough investigation of sexual behavior to date. Masters has divided the more severe problems in the male into three categories: type 1, inadequate erection; type 2, premature ejaculation; and type 3, non-emissive erection.

The problems which the female presents can be considered under frigidity. It is important to remember that a woman should not be considered frigid just because she does not achieve orgasm every time she has intercourse; most women don't. Many authorities now believe that many women can be completely fulfilled without ever having an orgasm.

Most women are not able to have an orgasm when preoccupied or fatigued, although they may be quite capable when relaxed. Even under such circumstances, they can enjoy the sexual act passively. The three major factors which the female may present as causes of a real frigidity or dyspareunia are 1) attitude toward sex, 2) relationship with husband, and 3) fear of pregnancy.

Of course, the first level of investigation by any physician should be to eliminate any possible organic causes for these disabilities, either impotence, frigidity, or dyspareunia. Actually, there are not a great many physical causes for sexual inadequacy in either sex. Pituitary tumors or related lesions or physical trauma may be causes. Various hormonal or structural defects causing underdevelopment of the sexual organs must be considered, but these usually are obvious from the history or physical examination. Severe retroflexion of the uterus or inadequate lubrication of the vagina can cause dyspareunia, or it may be a conversion symptom after an industrial accident with some totally unrelated physical injury. My purpose is not to describe these physical causes, yet I do not mean to minimize them, since occasionally a serious yet correctable condition will first be presented as a sexual problem.

What about these patients? Let us take the male first. The male who has inadequate erection usually has lost confidence in himself, both as an adequate marital partner and as an individual. Often the more he tries, the less success he has, and he then attempts to avoid intercourse. Important questions in the history should relate first to his past sexual experience. Has he always had this trouble, or is it a recent development? Did it occur with premarital sexual relations with

his wife or others? Is it now only limited to his wife, if he has had other exposures? Did it come on suddenly or slowly? Does he obtain an erection with manual manipulation? What sort of homosexual experiences has he had? What is his basic attitude toward sex and toward his wife both before the problem and now? Is his marriage happy, or are there other factors disrupting it which might lead to his rejecting his wife in this manner? Is he a chronic alcoholic? As Shakespeare said of alcohol and sex, "It increaseth the desire, but taketh away the performance!"

Concerning the male with premature ejaculation, the wife usually makes the complaint, or the husband seeks assistance because of her complaints. Although today, particularly in our middle class culture, the male tends to feel more inadequate when he cannot satisfy his wife, some authors suggest that this can be a learned pattern from exposure to prostitutes who are always in a hurry. I question such a conclusion. The same type of history is required in order to understand the situation.

Masters' theory that the man who has no orgasm with intercourse requires only reassurance, since his wife has her orgasm and he achieves it by other means, smacks somewhat of therapeutic nihilism; yet psychiatric treatment of such patients may be long and tedious. In oversimplified psychological terms, such men won't even give a woman their sperm. While the nonerective male is completely afraid of the vagina, the premature ejaculator seems to be in between.

In the female, a careful history frequently reveals a negative attitude toward sex, usually as a result of family standards or associated with earlier traumatic experiences. This may lead to either frigidity or dyspareunia. Fear of pregnancy may also be a deterrent to satisfactory sexual relations, although it may also be used as a screen to prevent unenjoyable relations. Basic dislike of the spouse, his body odor, his size, etc., may be offered as deterrents. The physician must use his clinical judgment to evaluate such complaints. Are they genuine, and can they be simply corrected, or are they merely superficial complaints to cover a deeper problem? Frequently, if we question this patient carefully, she will show us whether her demands are impossible or not.

The more acute situations probably will respond to a good history taking and counseling in the areas concerned. The more serious problems, however, can represent deep and severe emotional disturbances which require referral for psychotherapy. Rather than spend time where it will probably do no good, one should try to avoid the "impossible" situations. A couple who have been married five or ten years without consummating the marriage or seeking any real help for it represents a gigantic task which should not be undertaken lightly. The same would apply to the impotent male who has been so regularly, or even off and on, for many years. Any chronic untreated situation is usually presented for treatment unwillingly in the first place, further denying the possibility of a therapeutic success.

With reference to these latter problems, another excellent book is *Human Reproduction and Sexual Behavior,* edited by Charles W. Lloyd. In it Masters describes briefly some direct and "mechanical" methods of dealing with these problems. For example, for the premature ejaculatory male, he suggests repeated "teasing" by the wife, advancing to the point of reading a book with the penis in the coital position. Naturally, any such methods require a great deal of mutual desire, determination, and cooperation on the part of both and, while useful, must be understood to represent only a part of the treatment. The psychological factors cannot be easily overcome even by way of such training methods. One inventive colleague suggested that the patient's wife place ice cubes against her husband's scrotum if he were about to climax too soon. I wonder if such a cure might not be worse than the disease. In any event, it was not effective in the case I heard about. On the other hand, while I, personally, cannot ascribe to such heroic methods of treatment, some of these problems represent serious difficulties and do require imagination.

One of the most important things we have to offer such patients is hope and encouragement. They need a great deal of support and help in not feeling weak or freakish. In merely helping them to overcome their feelings of inadequacy, which are increased with each failure, we can be of tremendous help.

I spoke before about the significance of the history. Past experiences are the foundation of present sexual attitudes and behavior. The male

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who has been raised fatherless, sleeping with his mother and sucking her breast for comfort until 6, and then is placed in an orphanage until 16, has a hard row to hoe. I worked with such a patient for several years in psychotherapy without his obtaining sexual success. I was able to help him become more assertive and more adequate in his trade. As frequently happens, he married a girl who had severe dyspareunia, which didn't help the situation, and she would have no part of conjoint therapy, blaming all the difficulty on her husband.

There was, however, another man whose early life was reasonably normal, but he suffered severe trauma by witnessing an abortion performed on his mother in the next room, during which she hemorrhaged severely and almost died. His premature ejaculations were associated with his fear of getting his wife pregnant. Some superficial insight into this, along with a mature and loving wife, enabled him to overcome this readily. Excessive guilt over previous sexual behavior, frequently masturbation, can cause a great deal of inhibition in male or female patients. Although simple confession followed by medical reassurance does not immediately solve such problems, joint counseling with continued support and a real desire to help each other often can produce good results.

Our attitudes must be the same ones that we would apply to any other medical problem, genuine curiosity as to the cause and a desire to help without embarrassment. A little extra reading on sexual problems is necessary, particularly now that some real scientific work is being done. As you overcome your reluctance to enter this "forbidden" area, you will find more and more patients who present problems in their sexual life, and you will find yourself able to help many of them. Don't be in a hurry, as such problems take time to improve; however, helping a couple become sexually adjusted is a rewarding experience.

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DORSEY Season

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

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Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary: Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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A Case of Spontaneous Chylothorax

Report of a patient with this rare condition and discussion of its anatomic basis.

LOUIS R. SCHOOLMAN, MD

Spontaneous chylothorax is rarely seen in private practice or even in a large metropolitan general hospital. Among 1,168,760 general admissions to the Charity Hospital, New Orleans, from 1936 to 1956, Nix[1] found only four cases, which included cases of chylous effusion into the peritoneal and pleural cavities. There were no cases limited to the thorax.

CASE REPORT

A spinster, age 76, was treated on March 29, 1964, for a febrile respiratory infection. Her acute symptoms subsided within a week. On May 13, she was examined for congestive failure with 2+ pedal edema, palpable liver, and right pleural effusion. Her leukocyte and differential cell counts were normal; hematocrit value, 33%; and blood urea nitrogen, 18.5 mg/100 cc. X-ray on May 14 showed the lower two-thirds of the right lung field obscured by pleural fluid.

After the congestive failure had been relieved through diuretics and digitalis, I tapped her right chest and withdrew 350 cc of chylous fluid. Bacterial studies, including culture for tubercle bacilli, and a cell block examination, were performed and found negative.

An x-ray on May 20 showed only slight decrease in fluid. On May 26, 800 cc of fluid was drained from the right pleural cavity. Bacterial and cell block findings again were negative.

The effusion recurred, and on June 19, 1600 cc of fluid was aspirated. A fragment of pleura obtained for histologic examination was found to be normal.

An intravenous pyelogram showed a small kidney on the left, bilateral hydronephrosis, and, in the pelvis, a 10 cm calcified uterine fibroid which the roentgenologist considered not responsible for the hydronephrosis.

At this point, I thought that the patient should be hospitalized for more detailed studies of the genitourinary and gastrointestinal tracts, but she did not remain long enough for diagnostic studies to be completed.

One month later, after withdrawing 900 cc of fluid from the right side of the chest, I prescribed chlorambucil for her probable lymphoma. The patient took the 6 mg per day intermittently for two weeks and then stopped because it "upset her stomach."

On October 26, 750 cc of fluid was aspirated. The roentgenologist reading the check-up x-ray suspected a neoplasm in the mediastinum, but tomographic studies revealed only a calcified lymph node. The patient continued in fairly good health. Aspiration on February 9, 1965, showed no increase in fluid.

On March 12, I learned that her long-time per-

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sonal servant and cook had open pulmonary tuberculosis. I prescribed isonicotinic hydrazide and pyridoxine for the patient. On June 13, after 1,700 cc of fluid had been aspirated, an x-ray showed essentially clear lung fields. The leukocyte count was 8,900 with normal differential cell count; hematocrit value, 34%; sedimentation rate, 14 mm.

The patient consulted me on July 9 because of swollen feet. Examination revealed 3+ pedal edema and extensive right pleural effusion. Thiomerin was given. She refused to permit aspiration.

On July 15 she was found confused and aphasic and was admitted to the hospital. She was disoriented and mentally confused but had no paralysis. She had a grade 2 arcus senilis, complete cataract of the right lens and incomplete cataract of the left lens. The pulse rate was 96; blood pressure, 130/80; and heart sounds were clear and regular. The chest was flat to percussion up to the fourth rib on the right. Abdominal findings were essentially negative except for the calcified uterine fibroid extending above the pelvis.

Laboratory study revealed the following values: hemoglobin, 9.5 gm/100 cc; hematocrit, 29%; WBC, 5,200 with normal differential; serum urea nitrogen, 45 mg/100 cc; and fasting blood glucose, 94 mg/100 cc. Urinalysis showed 1.008, with protein, sugar, acetone, and microscopic findings negative. A review of the peripheral blood showed a reticulocyte count of 0.3% and no signs of nutritional anemia.

X-ray showed pleural fluid up to the third intercostal space. Electrocardiogram showed a right bundle branch block, SA tachycardia at a rate of 100, and non-specific myocardial change. The intradermal tuberculin reaction was positive and histoplasmin reaction negative.

I aspirated 1,300 cc of chylous fluid, and gave 500 cc intravenously. Six days later, 1,200 cc was aspirated and 500 cc given the same day and the next day. By the fourth her mind was clear, she spoke almost normally, and was ambulatory. The serum urea nitrogen had dropped to 24.5 mg/100 cc. She was discharged on July 26, free from edema, alert, and energetic.

During the next week at home her condition deteriorated rapidly. She ate poorly and irregularly, took salt at will, and refused medication. Pleural effusion mounted and pedal edema reappeared. She was hospitalized on August 5. On admittance, she was confused and hostile. Physical findings were essentially the same as those on her previous admission, but the hematocrit value had dropped to 25% and hemoglobin value to 7.5 gm/100 cc. Urinalysis showed 1+ protein and a high WBC. On admission the SUN value was 16.3 mg/100 cc, but rose during the next two weeks to 84.2 mg/100 cc. X-ray showed reaccumulation of right pleural fluid.

One the day of admission, 1,000 cc of chylous fluid was aspirated and 500 cc given intravenously. Another 500 cc was given the next day. On the third and fourth days, 500 cc of blood was transfused, raising her hematocrit to 37%. Because of the pyuria and rales in the left lung, streptomycin and penicillin were given intramuscularly for five days.

The patient remained hostile. On the fifth day, she turned her face to the wall and refused to talk or to take food. She lapsed into coma and died on August 30.

On postmortem examination, a retroperitoneal lymphoma invading the left kidney was found. The thoracic duct was not found. There was no evidence of tuberculosis.

DISCUSSION

Spontaneous chylothorax is usually associated with chylous ascites. A convenient etiologic classification was made by Hoffman.[2]

1. Compression or obstruction of the thoracic duct by malignant growths, primary or metastatic, including cystic hygroma of the neck and mediastinum.

2. Tuberculous adenitis causing compression or ulceration of the thoracic duct.

3. Thrombosis of innominate or left subclavian vein with obstruction of thoracic duct; aneurism of the duct itself.

4. Various medical entities such as filariasis and cirrhosis.

In 1911, Wallis and Scholberg[3] made a comprehensive survey of the literature from 1865 and found 27 cases of nontraumatic chylothorax and chylous ascites. The causes were:

Intra-abdominal carcinoma	10
Lymphoma	7
Tuberculosis	3
Cirrhosis of liver	3
Heart disease	1
Undetermined	3

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Only one patient survived.

Listerud,[4] in 1958, reviewed the literature from 1899 to 1956 and found 23 cases of chylothorax and chylous ascites. The causes were:

Lymphoma	6
Intra-abdominal carcinoma	3
Thrombosis of left subclavian vein	3
Tuberculosis	2
Retroperitoneal neurofibroma	1
Undetermined	9

Five of these patients survived.

Of the four cases reviewed by Nix,[1] the causes were:

Cirrhosis of liver	1
Adenocarcinoma of ovary	1
Lymphoma	1
Undetermined	1

The fate of the last patient was unknown; the others died.

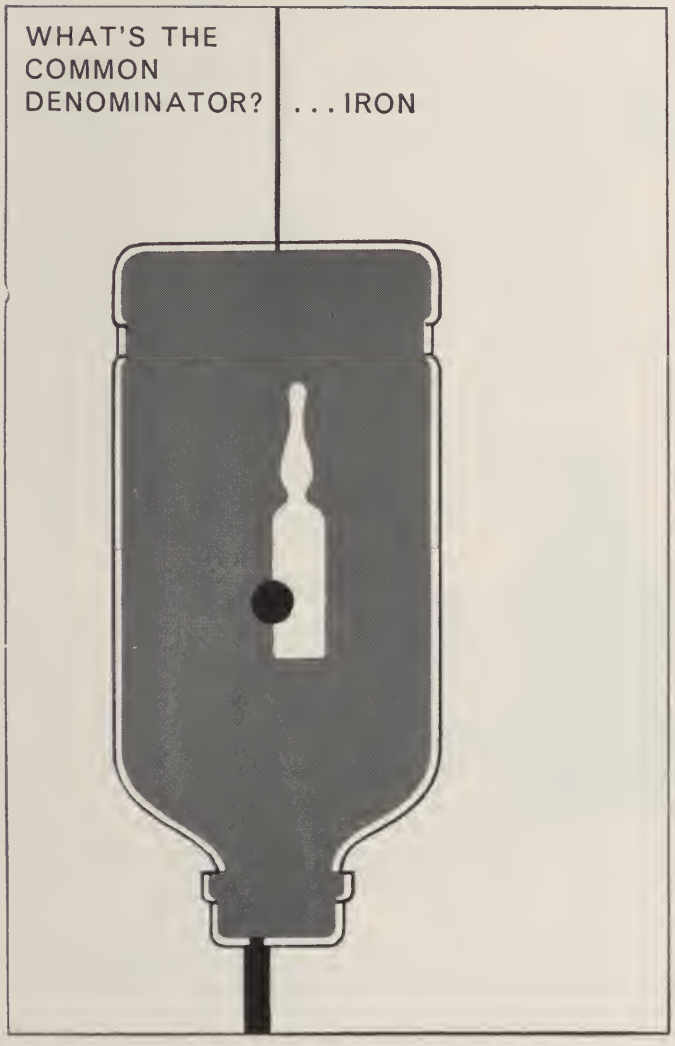
Nix[1] described the anatomic basis of chylothorax. The cisterna chyli, which collects the lymph from the lower extremities and the abdomen and the chyle from the intestinal lacteals, lies on the anterior surface of the second lumbar vertebra. Its extension upward is the thoracic duct, which enters the chest through the opening between the aorta and the azygos vein. It then enters the superior mediastinum behind the aortic arch and the subclavian artery, between the left side of the esophagus and the left parietal pleura. The thoracic duct, being extrapleural throughout, when obstructed or torn allows chyle to collect retropleurally and produce chylothorax only after rupture through the pleura at the lateral ligament. The thoracic duct crosses from the right of the midline to the left at the fourth and fifth thoracic vertebra. Obstruction or injury below this crossing will produce right chylothorax and above it, left or bilateral chylothorax.

3501 St. Paul Street
Baltmore, Md. 21218

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2. Hoffman, W.: *New York Med J* 57:1611, 1957.
3. Wallis, R. L. M., and Scholberg, H. A.: *Quart J Med* 4:153, 1911.
4. Listerud, M. B., et al: *Amer J Surg* 96:438, 1958.

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Homicides in Baltimore

SIDNEY M. NORTON
RICHARD T. SMITH, PhD

An analysis of homicides in Baltimore City in the 12-year period 1950-1961 reveals certain trends and characteristics of the victims. The highlights of these findings are:

SEX AND RACE—Most homicide victims are males, a high proportion being nonwhite moles.

AGE—Most victims were killed during the second and third decades of life. The overage age ot death for white victims is somewhat higher thon for nonwhites. The deviation about the mean is greater for whites than for nonwhites. The latter age distributions tend to approximate a normol curve pattern. The peak modal age categories for white femoles foll at the extreme ends of the age distribution, namely, under 15 ond 60 or over.

CRUDE RATE—Annual crude death rotes reflect certoin specific populotion trends within eoch sex-race group. Nonwhite mole homicide rotes have decreased over the 12-year period even though this group hos hod the highest crude rotes. Annuol crude rotes omong all other groups have remoined relatively stoble.

STANDARDIZED RATE—These rotes permit valid comparisons between groups ond over time. The death rates are highest omong nonwhite moles and have remoined in this relative position over the entire period. However, this same group has experienced o precipitous drop in the deoth rate. All other groups hove shown a slight rise in death rates. Nonwhite female deoth rotes ore second highest throughout the period, with one exception.

METHOD OF HOMICIDE—The most frequent method of homicide is the use of fireorms. The second method is the use of sharp, cutting, or piercing instruments. These two methods combined ore involved in almost eight out of ten homicides. The third most frequently used method is physical assault.

SITE OF HOMICIDE—Most men are killed in outdoor locations, while the modol cotegory for females is the victim's own residence.

TIME INTERVAL BETWEEN INJURY AND DEATH—Annual overoge time intervols between injury ond death ore higher for males than for femoles. Non-white femoles have the lowest averoge time intervol. Viewed over the 12-year period, overage time intervals within eoch sex-roce group do not indicate any apporent trend.

Numerous authors have investigated the broad spectrum of crime in our society.[1, 2] Criminologists have described the pattern of criminality as encompassing two major types: crimes of personal violence and property crimes.* Crimes of personal violence are characterized by differing levels of seriousness in that some result in injury and some in death. This paper deals with those crimes which resulted in death and are defined as homicides.

We have examined the pattern of homicide deaths that have occurred over a 12-year period in Baltimore City. This report analyzes the trends of these homicides and describes some of the pertinent characteristics associated with the victims.

Data Collection

All known cases of homicide occurring in Baltimore City during the period 1950 through 1961 were included in this investigation. The number of unknown homicides not brought to the attention of the authorities is estimated to be extremely low. Reported homicides were initially collected by means of a systematic check of death records. Using the death registration number on the death certificate, a means of cross-reference

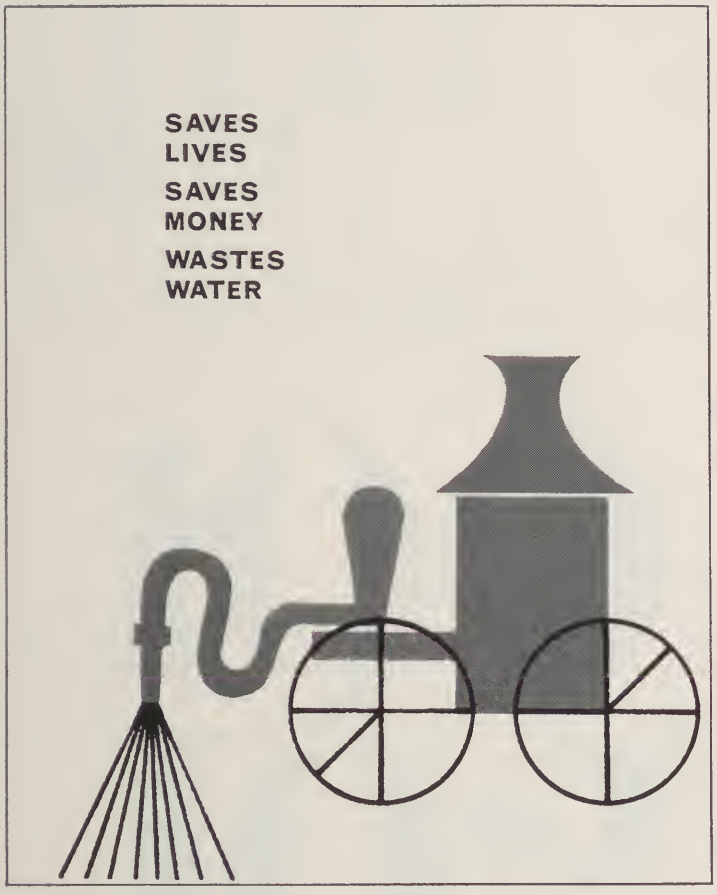
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Mr. Norton is director, Bureau of Vital Records, Baltimore City Health Department, and an assistant in the Department of Chronic Diseases, Johns Hopkins University School of Hygiene and Public Health.

Dr. Smith is assistant professor, Department of Chronic Diseases, Johns Hopkins University School of Hygiene and Public Health.

This study was made with the cooperation of Russell S. Fisher, MD, chief medical examiner of the State of Maryland, and Captain George Klemmick and Lieutenant Anton Glover of the Baltimore City Police Department's Homicide Division.

*As an example, in 1960 crime rates per 100,000 reported as offenses known to the police show the following pattern: Murder, 5.0; rape, 8.9; burgulary, 456.5; auto theft, 177.6. Figures obtained from the *Statistical Abstract of the U. S.*, 1964, 85th Edition, Washington, D. C., 1964, Table 197.



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TABLE 1

AGE DISTRIBUTION OF HOMICIDES BY SEX AND RACE, BALTIMORE CITY: 1950-61

Age at Death	Males						Females						Total	
	White		Non-white		Both		White		Non-white		Both			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
<15	13	7.4	21	3.4	34	4.2	16	17.7	19	10.4	35	12.9	69	6.4
15-19	13	7.3	40	6.4	53	6.6	5	5.5	19	10.4	24	8.7	77	7.1
20-24	9	5.1	79	12.6	88	11.0	5	5.5	22	12.1	27	9.8	115	10.7
25-29	15	8.6	103	16.6	118	14.8	11	12.0	30	16.4	41	15.0	159	14.9
30-34	19	10.8	104	16.6	123	15.4	10	11.0	36	19.7	46	16.8	169	15.9
35-39	26	14.9	83	13.3	109	13.6	10	11.0	28	15.3	38	13.9	147	13.7
40-44	16	9.1	60	9.6	76	9.5	7	7.7	11	6.0	18	6.5	94	8.7
45-49	13	7.3	47	7.5	60	7.5	2	2.2	7	3.8	9	3.3	69	6.4
50-54	22	12.5	41	6.6	63	7.9	6	6.6	6	3.1	12	4.4	75	7.0
55-59	10	5.5	18	2.9	28	3.5	5	5.5	4	2.2	9	3.3	37	3.4
≥60	20	11.4	28	4.5	48	6.0	14	15.3	1	0.6	15	5.4	63	5.8
Total	176	100.0	624	100.0	800	100.0	91	100.0	183	100.0	274	100.0	1074	100.0
Unk'n	1		1		2		0		1		1		3	
Ave. Age	39.0		34.0		35.7		34.9		29.5		31.3		34.9	

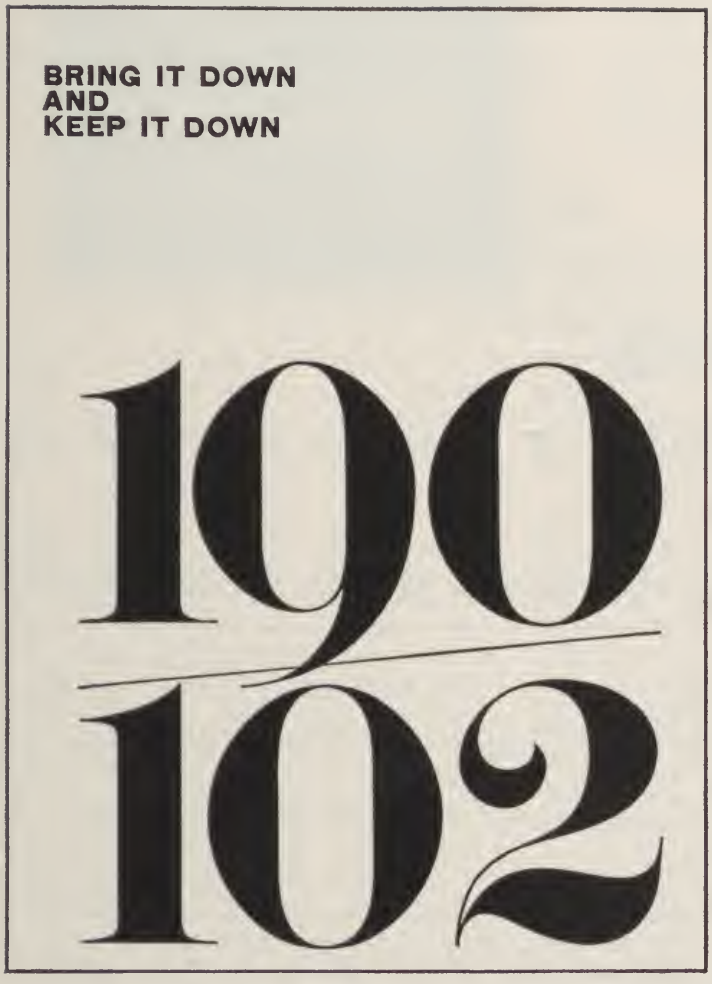
was established with the Police Department's homicide record and the Medical Examiner's postmortem record. Information from each of these sources was transcribed to forms specifically devised for this study. Data included such factors as date and location of death, manner of homicide, the victim's address, age, race, sex, and marital status, and other pertinent aspects of the homicide.

Findings

A total of 1,077 homicides occurred during the period of investigation. The victims do not represent a cross-section of the city's population in terms of race and sex. Indeed, males of both races account for 74.5% (802) of all known homicides. The one-sided picture of homicides is further evident when observed on the white-nonwhite factor. Homicides among white members of the community constitute 24.9% (268) of cases, while nonwhites account for 75.1% (809). Nonwhite males account for 58.0% (625) of the total. Following, in descending frequency, are nonwhite females, 17.1% (184); white males, 16.4% (177); white females, 8.5% (91).

The age distribution of homicide victims by sex and race is shown in Table 1. The overall average age at death is 34.9 years, which is essentially the midpoint in the person's life span when viewed in terms of life expectancy. The average age of female deaths, 31.3 years, reflects a younger victim population as contrasted with males, 35.7 years. This same female to male average age discrepancy holds for both whites and nonwhites and amounts to a difference of between four and four and one-half years. Nonwhite females tend to be victims at a younger age, on the average, than any of the other sex-race groups. One striking feature of this table is the high proportion of deaths in the very young and the very old age groups among white females.

If one were to plot bar graphs using the age distributions for each group, it would bring into relief the fact that both male and female nonwhite distributions tend to reflect a normal curve pat-



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tern, whereas for white people of both sexes, the pattern appears more dispersed across all ages. This contrast is particularly distinct for the male distributions. Homicides among whites seem more likely to occur in any age category, while among nonwhites most victims are in the 25-39 age span. This observation is partly a reflection of higher proportions of younger ages in the nonwhite population as contrasted with the white population.

To obtain a more meaningful interpretation of the differential pattern of homicides in the community, it is necessary to take into account the population distributions for each sex and race category. The result is the crude rate.* The crude rate is specific to the particular population base used and therefore is not directly comparable to a crude rate obtained by using a different population. Thus, comparisons in Table 2 can be made only horizontally within each row and not vertically within a given column.

Annual crude death rates by sex and race for the 12-year period are presented in Table 2. This table permits an overview of trends in crude rates

Appreciably high crude rates are observed for nonwhite males. Annual crude rates within this group show a peak rate in 1950 of 56.2 per 100,000 and diminish over 12 years to a crude rate of 31.8 per 100,000 in 1961. The crude homicide rate for the U.S. nonwhite male population in 1961 was 33.6 per 100,000.[3] The trend among white males over this period shows a slight increase, from a crude rate of 5.7 per 100,000 in 1950 to 6.6 in 1961. The crude homicide rate for the U.S. white male population in 1961 was 3.6 per 100,000.[3] The crude rates for white females during this period show a slight rise from 1.9 per 100,000 in 1950 to 2.6 per 100,000 in 1961. Among nonwhite females, there is a general indication of decreasing crude rates after the peak rate of 14.6 per 100,000 in 1954.

The annual crude death rate for all cases in Baltimore City was 9.8 per 100,000 in 1951 and 11.5 in 1960. Crude death rates for homicides in the United States population during the same period are almost one-half of the Baltimore City rates. In 1951, the U.S. death rate for homicides was 4.9 per 100,000 and in 1960 it stood at 4.7.[3] The U.S. rates are diluted by the inclusion of rural and other less urban areas where criminal homicide rates are low. Crude rates for urban areas of 250,000 population or more probably are comparable to Baltimore City rates.

TABLE 2

ANNUAL* CRUDE DEATH RATES FOR HOMICIDES, BY SEX AND RACE, BALTIMORE CITY: 1950 to 1961

(Rates per 100,000)

Sex and Race	Year of Homicide												Total No. Cases
	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	
MALES													
Total	17.8	15.4	15.0	13.7	13.8	12.9	11.4	14.3	14.1	13.7	17.4	15.7	800
White	5.7	2.3	4.4	4.8	4.0	2.5	4.1	4.8	4.2	6.0	6.1	6.6	176
Nonwhite	56.2	54.7	45.0	37.6	38.6	37.9	28.0	34.7	34.2	28.6	38.4	31.8	624
FEMALES													
Total	3.5	4.3	3.9	2.9	5.9	5.1	4.3	4.5	6.8	4.9	5.8	4.3	274
White	1.9	1.9	1.4	2.2	2.6	2.6	0.9	1.8	4.3	2.2	2.5	2.6	91
Nonwhite	8.6	11.6	11.1	4.5	14.6	11.2	12.2	10.4	12.0	10.3	11.8	7.4	183

* Specific sex-race total populations for other than the census years 1950 and 1960 estimated by interpolation.

*Crude Rate = $\frac{\text{no. of cases}}{\text{total population}} \times 100{,}000$

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"I can't sleep at night"



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Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

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TABLE 3

AGE-ADJUSTED* STANDARDIZED† ANNUAL DEATH RATES FOR HOMICIDES, BY SEX AND RACE, BALTIMORE CITY: 1950 TO 1961

(Rates per 100,000)

Sex and Race	Year of Homicide												Total No. Cases
	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	
MALES													
Total	15.2	13.5	13.5	12.5	12.8	12.0	10.7	12.4	13.6	13.5	17.5	16.0	800
White	5.3	2.2	4.3	4.4	3.9	2.3	3.8	4.6	4.2	5.8	5.9	6.5	176
Nonwhite	47.6	48.5	40.1	35.5	37.2	37.1	27.2	35.8	33.2	29.6	41.6	33.9	624
FEMALES													
Total	3.2	3.9	3.4	2.9	5.6	4.8	4.2	4.4	6.5	4.8	5.7	4.4	274
White	2.0	1.8	1.3	2.2	2.6	2.6	0.9	1.9	4.2	2.2	2.4	2.5	91
Nonwhite	6.7	10.4	9.9	4.0	12.1	10.3	11.3	8.8	11.0	8.8	10.8	7.0	183

* Specific sex-race-age population distributions for other than the census years 1950 and 1960 estimated by interpolation using age-specific categories.

† Standard population: 1960 census of total population for Baltimore City.

A useful method for comparing rates among different population groups is called the direct method of standardization.[4] This method takes into account differences in sex, race, and age group distributions among the several classes being investigated as well as changes in these distributions over time. The resulting death rates are hypothetical rates that would obtain if each set of age-specific rates, for each sex-race category, were compared using identical populations.

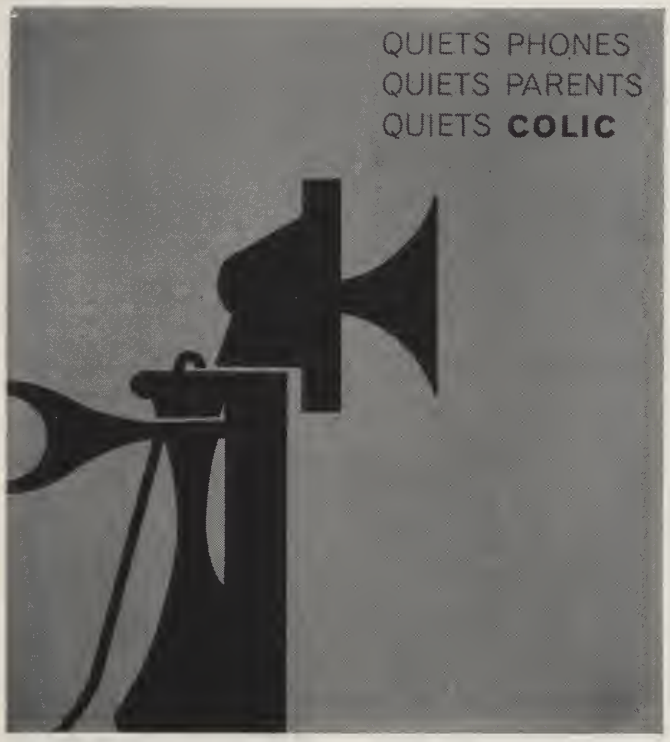
The results of this standardization method for annual homicide rates observed for each sex-race group are shown in Table 3. By using this method, comparisons can be made both across and down the table. The striking feature of these standardized rates is the relatively high rate among nonwhite males for the entire 12-year period. The second important facet of this table is the precipitous decline in the annual rates for this same group. This is perhaps the more significant finding of the two mentioned. Furthermore, this trend among nonwhite males should be viewed in light of the fact that no other sex-race category shows an overall decline in rates for this period.

Among white males, the death rates have increased slightly over the 12 years but, in contrast to the nonwhite males, they are considerably lower. For females, the rates for nonwhites have remained consistently higher than whites throughout this period. In addition, nonwhite females have higher death rates than white males. In general, throughout the period under investigation, the nonwhites experienced higher homicide rates than the whites.

Other important characteristics of homicide pertain to the manner of homicide, the place where death occurred, and the time interval between injury and death. These factors will be discussed.

The methods employed in homicide are presented in Table 4. The most prevalent method is the use of firearms. This is characteristic of all sex and race categories except nonwhite males. Sharp, cutting, or piercing instruments, such as a knife, rank first for this group, with firearms a close second. Combined, these two methods account for 79.3% of all homicides in this group. These same methods account for 64.2% of homicides among nonwhite females. In contrast, the use of firearms and sharp instruments cause 58.6% of the deaths among white males and

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TABLE 4

METHOD OF HOMICIDES BY SEX AND RACE, BALTIMORE CITY: 1950 - 61

Method of Homicide	Males						Females					
	White		Non-white		Both		White		Non-white		Both	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Firearms	74	41.7	240	38.5	314	39.2	37	40.6	61	33.2	98	35.7
Sharp instrument	30	16.9	255	40.8	285	35.6	13	14.3	57	31.0	70	25.4
Assault	46	26.0	70	11.2	116	14.5	17	18.7	28	15.2	45	16.4
Strangulation	3	1.7	1	0.2	4	0.5	12	13.2	20	10.9	32	11.6
Legal	5	2.8	34	5.4	39	5.0	0	0	0	0	0	0
Other*	19	10.9	24	3.9	43	5.2	12	13.2	18	9.7	30	10.9
Total	177	100.0	624	100.0	801	100.0	91	100.0	184	100.0	275	100.0

* Includes poisoning, drowning, crushing, causing to fall, burning, exposure (neglect), and miscellaneous other causes excluding unknown causes.

54.9% among white females. The same pattern in the use of these methods was observed by Wolfgang in his study of criminal homicides in Philadelphia for the period 1948 to 1952.[5]

Death by sharp instruments is more characteristic of nonwhite than of white homicides. On the other hand, physical assault, such as being beaten or struck by a blunt instrument, accounts for a greater proportion of cases among whites than among nonwhites. A means predominantly used for females is strangulation. This finding is expected, since strangulation is likely to be used by the stronger male offender against his victim.

The method labeled legal homicide relates to

TABLE 5

SITE OF HOMICIDES BY SEX AND RACE, BALTIMORE CITY: 1950 - 61

Site of Homicide	Males						Females					
	White		Non-white		Both		White		Non-white		Both	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Own residence—indoors	38	21.6	159	25.5	197	24.7	54	60.0	111	60.6	165	60.4
Own residence—outdoors	3	1.7	26	4.2	29	3.6	1	1.1	7	3.8	8	2.9
Other residence—indoors	14	8.0	103	16.5	117	14.6	8	9.0	20	11.0	28	10.2
Other location—outdoors	74	42.1	272	43.5	346	43.4	19	21.1	38	20.8	57	20.9
Place of employment	24	13.6	1	0.2	25	3.1	2	2.2	0	0	2	0.7
Tavern or bar	8	4.5	36	5.8	44	5.5	1	1.1	2	1.1	3	1.1
Prison or jail	2	1.1	10	1.6	12	1.5	0	0	0	0	0	0
Other	13	7.4	16	2.7	29	3.6	5	7.7	5	2.7	10	3.8
Total	176	100.0	623	100.0	799	100.0	90	100.0	183	100.0	273	100.0

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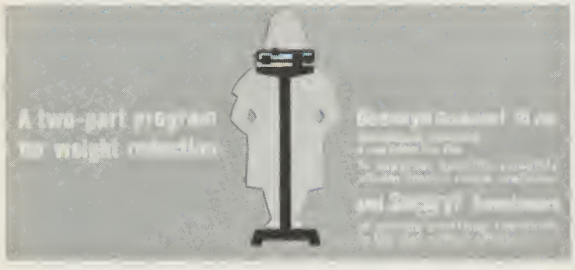
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either judicial execution or justifiable homicide by the police. This method is characteristic of males only and primarily occurs among nonwhite males. Usually it is the result of police action in the line of duty, when a criminal suspect resists arrest or attempts escape. Of the 39 cases labeled legal homicide, the records show that 27 cases (69%) were due to injury by the police while the remaining 12 cases (31%) were legal executions.

The ecological distribution of homicides may be significant in relating the overall pattern of this crime with factors associated with the social milieu. In this respect, a meaningful distinction can be drawn between locations associated with the victim's own environment and the more general area of public domain. A homicide committed in the victim's home may involve a different set of factors in the victim-offender situation than one committed in some other private or public location. Furthermore, one can differentiate other factors in homicides that occur solely in the victim's home as being either domestic precipitated or intruder precipitated events.

In Table 5, homicides have been categorized into a number of primary sites, and the distributions shown are by sex and race. The major sites listed are residence, outdoor non-residence, place of employment, tavern or bar, prison or jail, and miscellaneous places. The residence category has been further delineated by taking into account the victim's status with reference to the household. Either the victim resided in the household ("own residence"), or the homicide occurred in some other household ("other residence"). Such homicides were also classified according to whether they occurred indoors or outdoors. "Other location—outdoors" includes such places as street, park, vacant lot, or river. The category, "other" is a potpourri of sites including automobile, public or commercial building, transportation terminal, or hotel.

Among male victims, the modal group falls into the category of outdoor locations. These homicides probably involve the victim in situations related to aggravated assault, robbery, and intentional murder. Both white and nonwhite male distributions show that a little over two out of every five homicides occur outdoors. The second most frequent site for males of both races is inside the victim's own residence. One out of every five white males and one out of four nonwhite males are killed in their home. These cases usually involve domestic issues within the family.

For nonwhite males, the third most frequent site of homicide is in a residence other than the victim's. The high proportion of cases occurring in proximity to the victim's residence, 29.7%, increases to 46.2% if other residential locations are included. This combined figure outranks all other categories in the nonwhite male group. The comparable figure for white males is 31.3%, which does not outrank the first category mentioned for this group, namely, other outdoor locations.

The third most frequent site of homicide for white males is his place of work, which presents a sharp contrast to that noted for nonwhite males. The residual categories shown in Table 5 for males account for fairly small proportions in each group.

For females, a distinct contrast is observed for the site of homicide and the proportion of cases in this modal category. Three out of five women are killed within the victim's own residence. Probably such homicides relate to domestic matters within the family or at least within the social web of proximate personal relations. The other factor pertinent to homicides in this situational context is that of intruder precipitated action. Both female groups show considerably higher proportions of cases observed for homicides occurring in proximity to residential locations. The combined figure for white females is 70.1% and for nonwhite females it is 75.4%.

One out of five females are victims in other outdoor locations. This site is ranked second in frequency. This situation probably involves an element of isolation from other persons, since most of the sites in this category are places that would be devoid of individuals at some time during any 24-hour period.

The final factor concerns the time interval between injury and death. In each case, the interval has been established from the records of the Medical Examiner's office and the Police Department. In a number of cases, the time of injury could only be estimated by the police or the coroner's office. In like manner, the time of death had been established afterward.

The average time interval has been calculated for each sex-race group for the years 1950-1961. These figures are presented in Table 6. The averages are not based on the original numbers in each

TABLE 6

AVERAGE TIME INTERVAL* BETWEEN INJURY AND DEATH FOR HOMICIDES, BY SEX AND RACE, BALTIMORE CITY: 1950 TO 1961

Year of Death	Sex and Race					
	Males		All Males	Females		All Females
	White	Non-white		White	Non-white	
	AVERAGE TIME INTERVAL					
1950	0-18	1-08	1-06	0-02	0-10	0-09
1951	0-02	1-17	1-13	0-02	1-05	0-20
1952	1-08	0-16	0-19	0-07	1-06	1-01
1953	1-13	1-09	1-10	1-09	0-05	0-21
1954	1-11	1-04	1-05	1-19	0-07	0-18
1955	1-16	1-05	1-06	1-03	1-09	1-08
1956	0-22	2-01	1-19	0	0-05	0-05
1957	1-20	1-16	1-17	0-16	0-02	0-07
1958	2-20	1-08	1-16	0-10	0-22	0-17
1959	4-05	0-23	1-14	0-04	0-16	0-12
1960	0-19	1-08	1-05	1-18	1-13	1-14
1961	0-15	1-05	1-01	4-02	0-23	1-23
Total	1-09	1-08	1-08	1-03	0-19	0-22

* Average time interval is shown as: No. of days — No. of hours.

group for these years. Insufficient record information resulted in the loss of cases in each of these groups. The residual number of cases in each sex-race group, for all years, are as follows: white males, 133; nonwhite males, 528; white females, 58; nonwhite females, 134.

The most noticeable difference in average time intervals occurs by sex. Female victims of homicide tend to survive for a shorter time than do males. In addition, nonwhite females show an overall average time lapse of 19 hours, while white females show an average of 27 hours. This latter average comes closer to the total average time intervals observed for both male groups. There appears to be no consistent trend in average time intervals over the 12-year period.

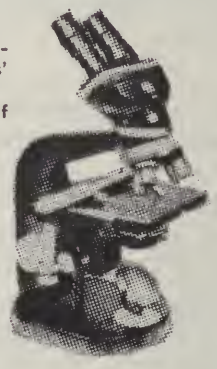
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Baltimore City Health Dept.
Municipal Building
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CANCER OF THE NASOPHARYNX

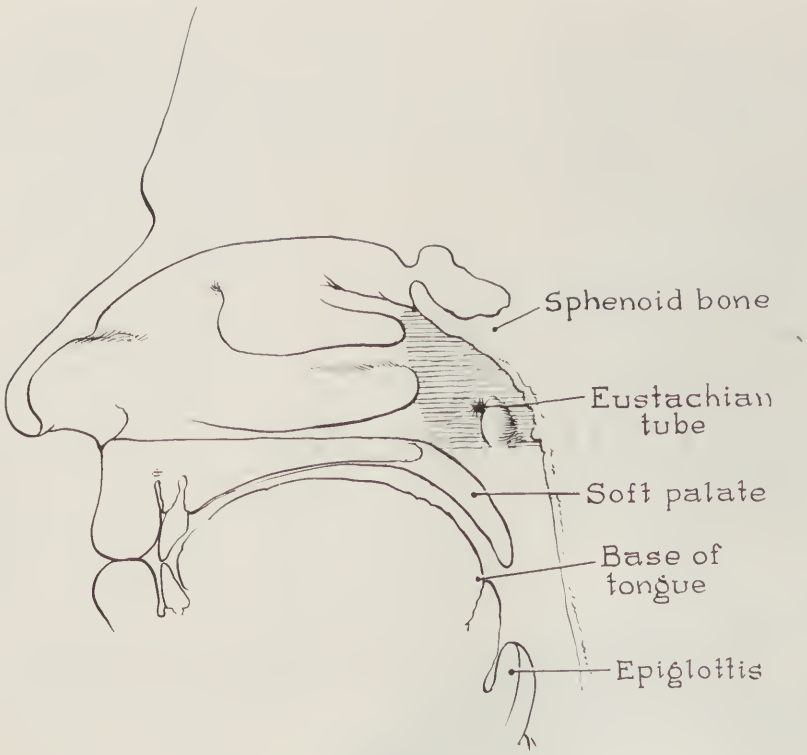
JERRIE CHERRY, MD
J. STEWART LOTT, MD
R. ROBINSON BAKER, MD

Cancer of the nasopharynx accounts for approximately 1% of all cancers occurring in the United States. Fifty per cent of these patients can be cured if diagnosis is made early in the course of the disease. However, there are still many patients being diagnosed in the late stages of disease. The average time lag from onset of symptoms to diagnosis is 11 months.[3] Awareness of the symptoms and signs of nasopharyngeal carcinoma, coupled with an increased use of cell washings and biopsy, will lead to earlier diagnosis and more cures.

Incidence.—This disease occurs more commonly in Caucasians than Negroes [3–5] and is three times as common in men than in women.[3, 4] The average age of onset is 51 years.[2, 3]

Anatomy.—The nasopharynx (Fig) is a medial space just posterior to the nose, beneath the sphenoid bone, anterior to the cervical vertebrae C_1 and C_2, and posterior to the dorsum of the soft palate. The lateral extent of this space is bounded by the eustachian tube orifices. This nasopharyngeal space is lined by respiratory epithelium and contains numerous lymphoid elements which in

From the Department of Otolaryngology, Division of Radiotherapy, and the Department of Surgery, The Johns Hopkins University School of Medicine.



The nasopharynx (shaded area) is bounded anteriorly by the middle turbinate of the nose, superiorly by the sphenoid bone, inferiorly by the soft palate, and posteriorly by the prevertebral fascia.

children and adolescents form the pharyngeal tonsils. This space is hidden from direct view and easy palpation. It is bounded on four sides by bone and is visualized only with an indirect mirror or nasopharyngoscope.

Symptoms.—The presenting symptoms vary with the anatomic location of the primary lesion within the nasopharynx and the biologic behavior of the tumor. They fall into three general patterns: 1) lesions causing local obstruction of the nose or eustachian tube; 2) lesions causing cranial nerve involvement and bony erosions; 3) lesions which metastasize to regional lymph nodes or to distant areas. Those lesions causing obstructive signs, such as nasal congestion, epistaxis, hearing loss, tinnitus, and otitis media, are most common. The group of patients presenting with cervical metastasis form the next most common group, followed by those patients presenting with cranial nerve involvement.[2, 3, 5] Few patients present with headache or dizziness.[3, 4]

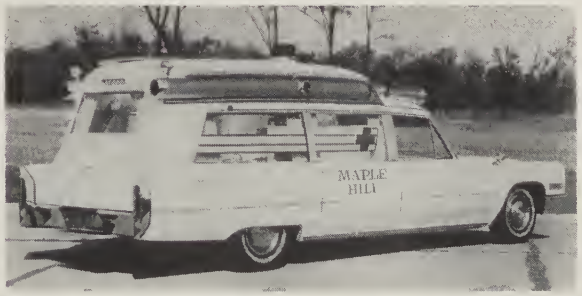
Pathology.—Most malignant tumors in this region are carcinomas. These tumors characteristically are poorly differentiated and are associated with a high incidence of cervical lymph node metastases. In addition to squamous cell carcinomas, lymphoepitheliomas are commonly encountered in this anatomic area. These tumors are of epithelial origin but contain a heavy infiltration of lymphocytes. Small lesions within the nasopharynx are frequently associated with massive cervical metastases. Malignant lymphomas, such as reticulum cell sarcoma and lymphosarcomas, are also found occasionally in the nasopharynx.

A method of staging nasopharyngeal lesions has been suggested by Geist and Portmann.[1] A Stage I lesion is confined to the nasopharynx without palpable cervical lymph nodes or cranial nerve involvement; Stage II lesions have cervical node involvement but no evidence of cranial nerve involvement or x-ray evidence of erosion of the skull; Stage III lesions have local bony invasion of the skull with neurological signs; Stage IV lesions have distant metastases.

Therapy.—Radiotherapy is the treatment of choice for the primary nasopharyngeal lesion. When the aim of treatment is cure, either supervoltage or Colbalt 60 beam therapy is superior to the conventional x-ray from the standpoint of

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both normal tissue tolerance and tumor destruction. Radium therapy can be used occasionally to supplement external beam radiotherapy if higher local dosage is required.

The tumor destructive dose for lymphosarcoma or reticulum cell sarcoma is of the order of 3,000 rads in three to four weeks, including the node bearing areas of the neck and possibly the upper mediastinum in the treatment fields. For lymphoepithelioma, 4,000 to 5,000 rads in four to five weeks will be required. Squamous cell carcinoma, being still more resistant, necessitates more localized treatment and higher dosage in the range of 5,000 to 6,000 rads in five to six weeks.

Involvement of the base of the skull and cervical lymph node metastases are unfavorable prognostic signs; such cases are seldom cured. Incurable disease may be effectively relieved and restrained by radiotherapy in dosage designed to shrink the tumor mass without producing significant normal tissue reaction. If the primary nasopharyngeal lesion has been controlled for a period of four to six months, surgical excision of recurrent or persistent neck nodes may be done with a slight chance of cure.

STAGE OF DISEASE CORRELATED WITH FIVE-YEAR SURVIVAL RATES[5]

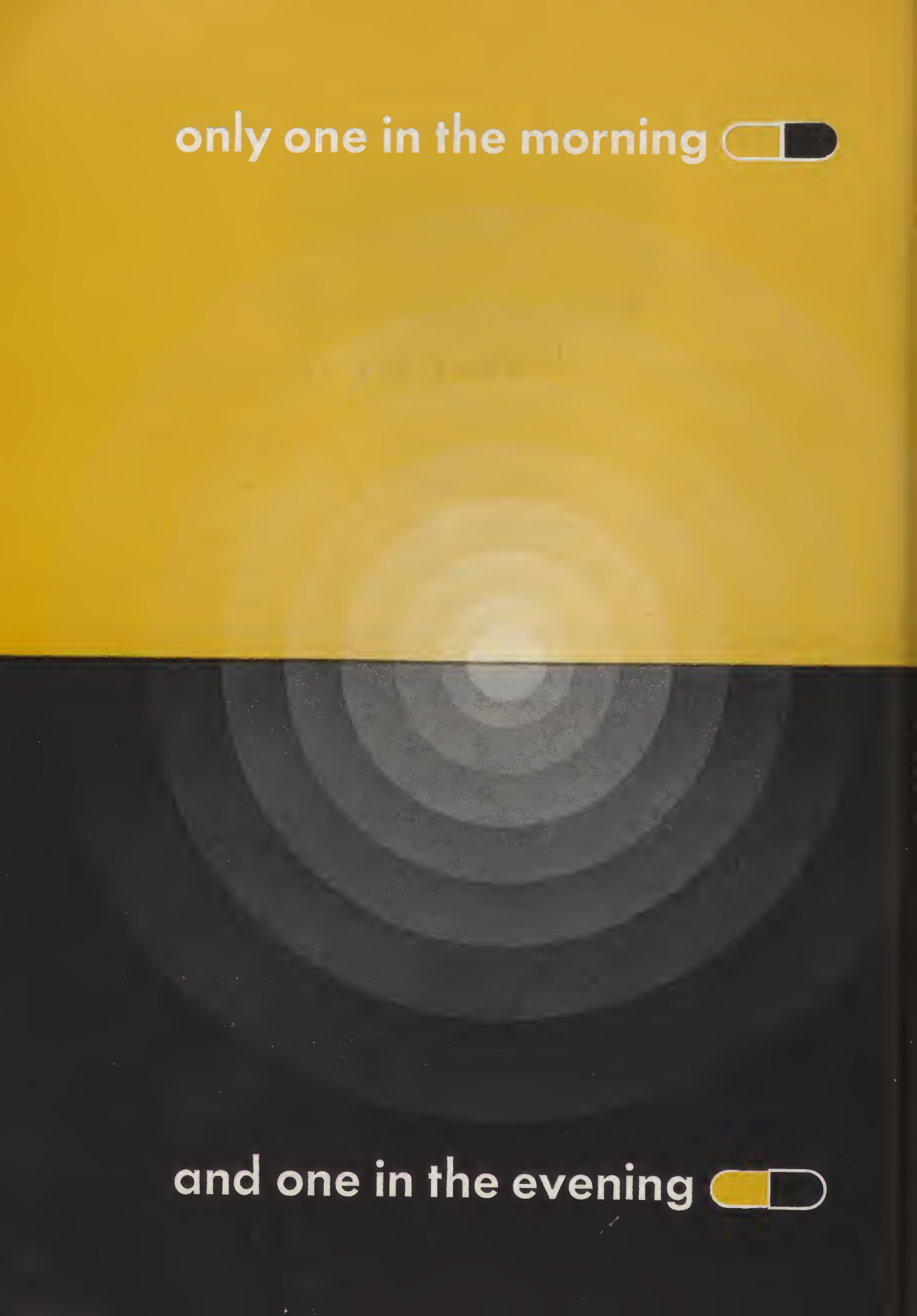
Stage	5-year Survival Rate
I	50%
II	40%
III	16%
IV	Incurable

Survival figures correlated with the stage of disease are presented in the Table.

The Johns Hopkins University School of Medicine
Baltimore, Md. 21205

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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angialagy, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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ARRHYTHMIAS SECONDARY TO CRANIOCEREBRAL TRAUMA.

Review of the literature and report of a case

E. G. ELIAS, MD
Resident surgeon, Union Memorial Hospital

WILLIAM FINNEY, MD
Neurosurgeon, Union Memorial Hospital

Cardiovascular changes may take place secondary to intracranial damage.[1–12] These cardiovascular changes differ from the electrocardiographic changes seen with high blood pressure and slow pulse. The ECG changes also vary from tachycardia, auricular fibrillation, bradycardia, to changes in the QT complex.[4]

The source of intracranial damage may be either spontaneous such as intracerebral hemorrhage, or traumatic; ie, concussion, hemorrhage, or occurring during pneumoencephalography[6] and brain surgery.[13]

The route of the cerebrocardiac syndrome has been traced by stimulating different areas in the brain electrically or mechanically or by blocking the vagi chemically, producing various responses.

Cushing[7] was one of the first to describe slow pulse and increased blood pressure secondary to increased intracranial pressure. Walker[8] demonstrated immediate slow pulse after cerebral concussion, which could be prevented by sectioning of the vagi.

Jacobson and Danufsky[4] showed that abnormalities of cardiac function can be produced by cranial trauma in mice. These changes occurred immediately after trauma, suggesting that they are due not to increased intracranial pressure but to impulses through nerve fibers of the cholinergic group, probably by those of the vagus, which disappeared by injection of atropine.

Increased amplitude of T and RS waves during brain surgery has been reported, as well as prolongation of the Q-T segment in intracerebral hemorrhage and high intracranial pressure.[5]

Ventricular tachycardia has been reported following head trauma[9] and associated with internal hydrocephalus.[10] Abnormalities of cardiac rate and rhythm are common in bulbar poliomyelitis.

White[11] found that electrical stimulation of the lateral wall of the third ventricle induced tachycardia and that mechanical stimulation of the optic chiasma induced bradycardia, premature systoles, nausea, vomiting, and increased peristalsis. This would not occur if the patient had previously received atropine.

Beatie et al[12] produced ventricular premature systoles by stimulating the hypothalamus. Others reported, in addition, the production of sinus tachycardia and prolonged conduction time.

Abeles and Schneider[6] reported that pneumoencephalography may produce ECG changes compatible with stimulation of the pacemaker through the vagus. These changes include sinus arrhythmia, sinus bradycardia, sinus tachycardia, migration of pacemaker between S-A and A-V nodes, transitory nodal rhythm.

The case we are to present suggests that subdural hemorrhage and increased intracranial pressure can manifest themselves clearly by arrhythmias.

Case Report

A 62-year-old white man was admitted to the Union Memorial Hospital, because of unconsciousness after a fall down 15 steps. There was no history of syncope or dizziness. He had, however, been seen in the outpatient departments of other hospitals because of nonspecific abdominal complaints and headaches. There was no history of cardiac disorders.

The patient had consumed alcoholic beverages before his fall.

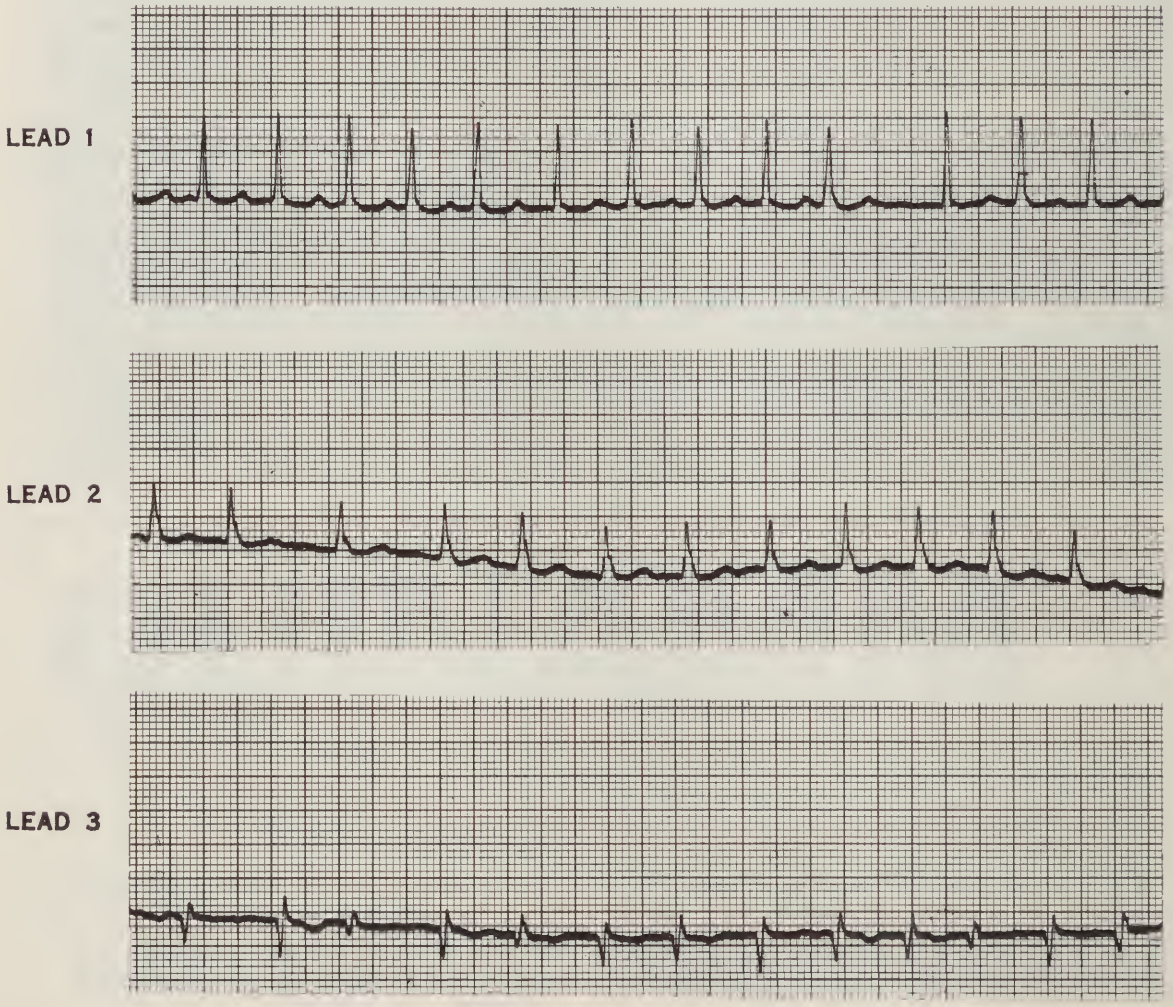
On admission, he was stuporous but arousable and would follow simple commands. There were no localizing neurologic signs nor bleeding from ears, nose, or throat. The patient was believed to be inebriated, and he was placed under observation.

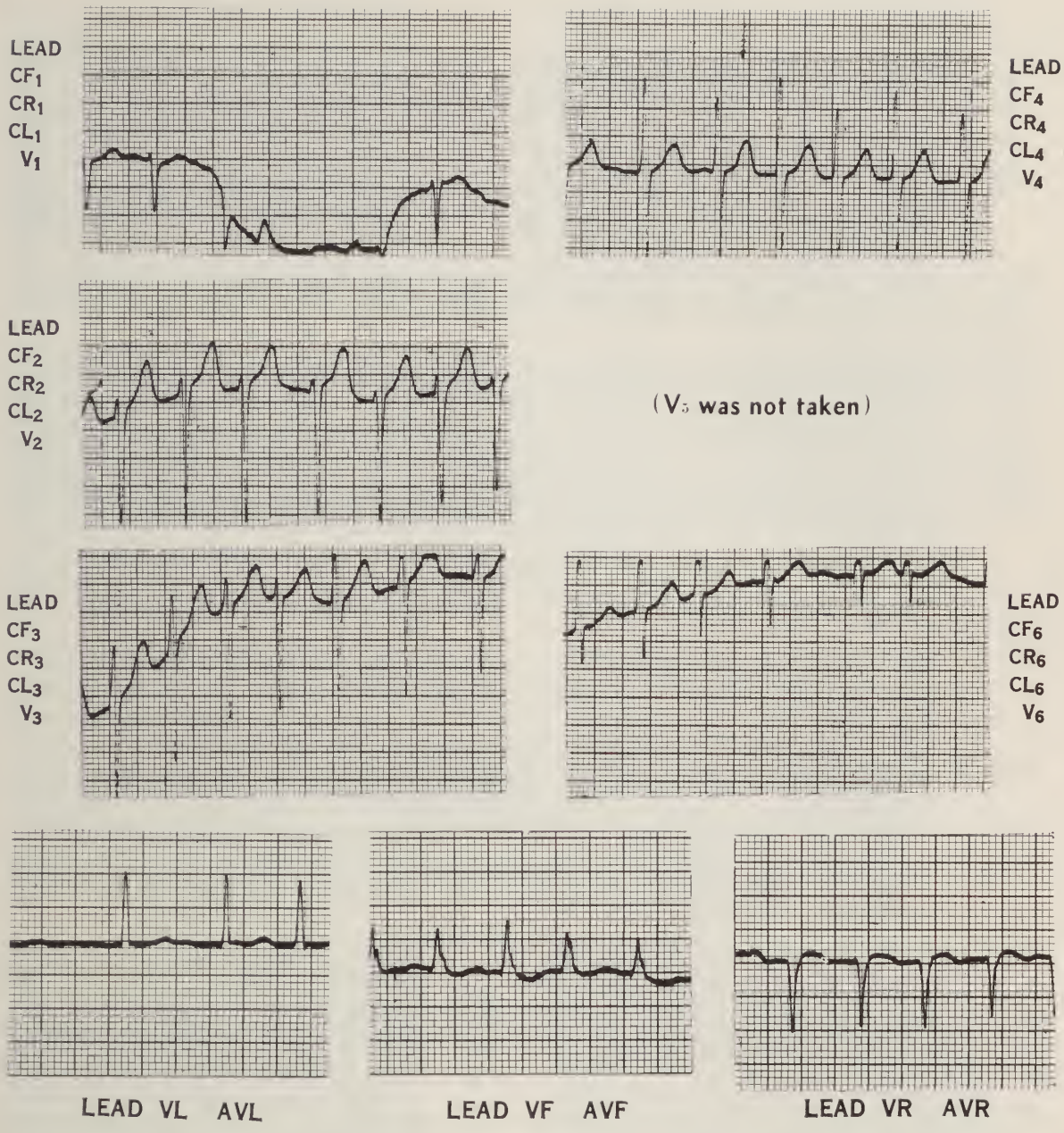
Physical findings on admission were: pulse, 80 and irregular blood pressure, 180/110; respirations, 20; temperature, 97.6. Other physical findings were negative except for abrasions on the right anterior chest wall. X-ray of the skull showed a linear fracture of the left temporal bone. The pineal gland was calcified midline.

The patient was kept under close observation. Twelve hours later his neurologic condition was unchanged, although the patient developed irregular pulse (irregular irregularity). ECG showed auricular fibrillation with ventricular response of 130+/min (Fig 1).

At that time lanatoside C (Cedilanid) and digitoxin were administered. Blood pressure was 160/100; rectal temperature, 102; lumbar puncture was done with opening pressure of 290 mm

Fig 1





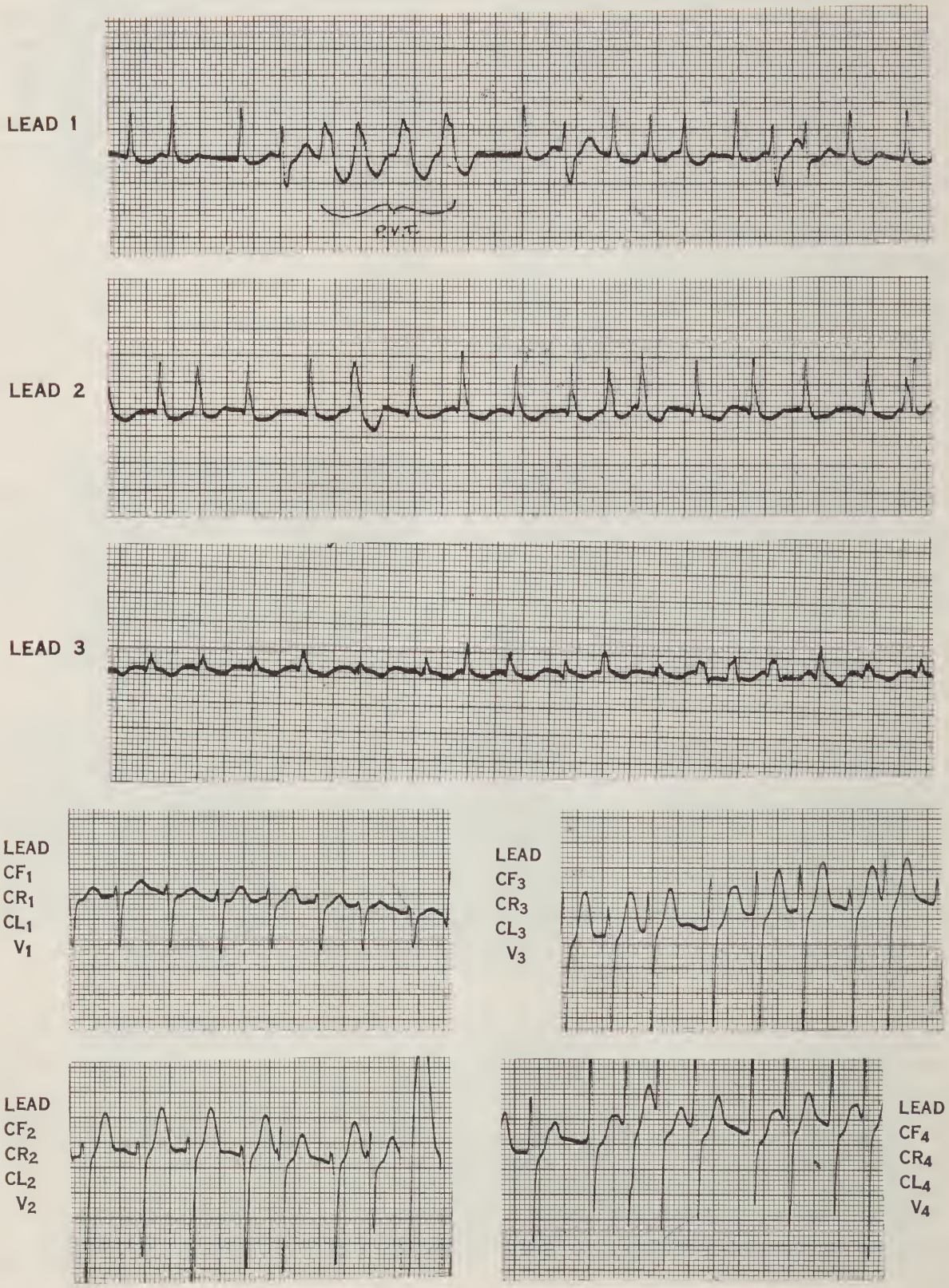
H_2O (patient flat), and the cerebrospinal fluid was xanthochromic with red blood cell count of 5,643/cu. mm.

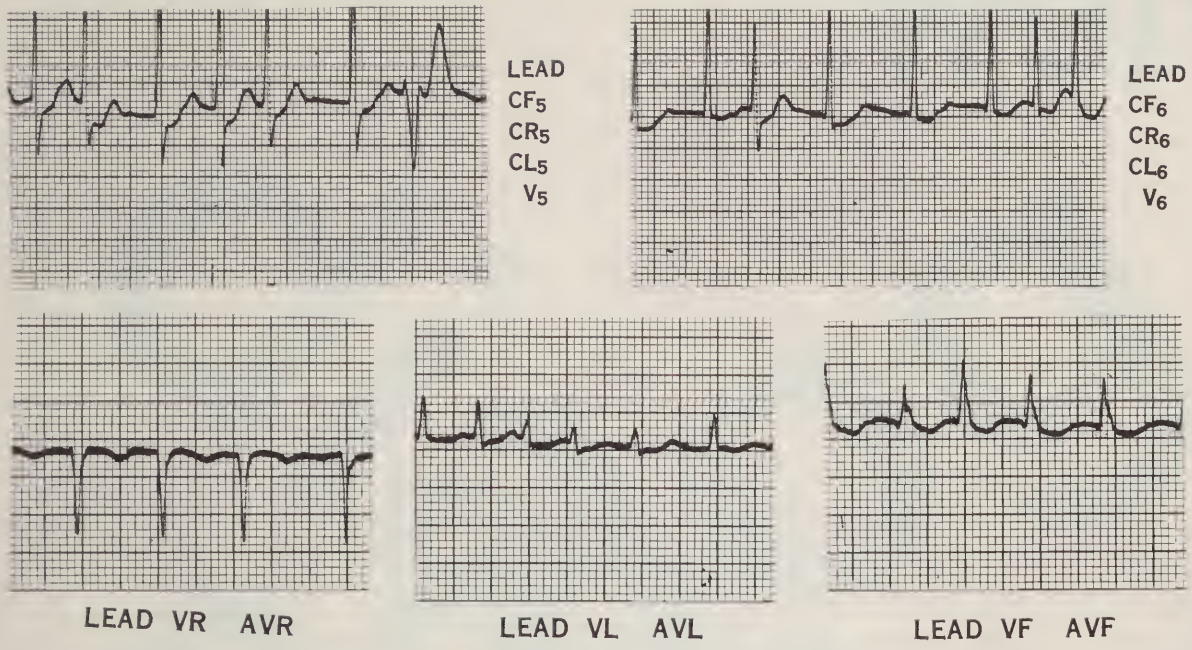
Up to that time, the presumed diagnosis was stroke or subarachnoid hemorrhage. The visascope was connected to the patient. He received repeated doses of lanatoside C until full digitalization 1.6 gm was attained, but there was no change in cardiac rate.

Six hours later, 1 gm of procainamide hydrochloride (Pronestyl) was given intravenously. One hour later there was still no response. The ECG showed ventricular tachycardia and frequent systoles with aberrant conduction and occasional PVC, as well as ST, changes of myocardial ischemia (Fig 2).

At that time the pupils were still equal and reacted to light. There was no papilledema or pathologic reflexes. The only new neurologic

Fig 2

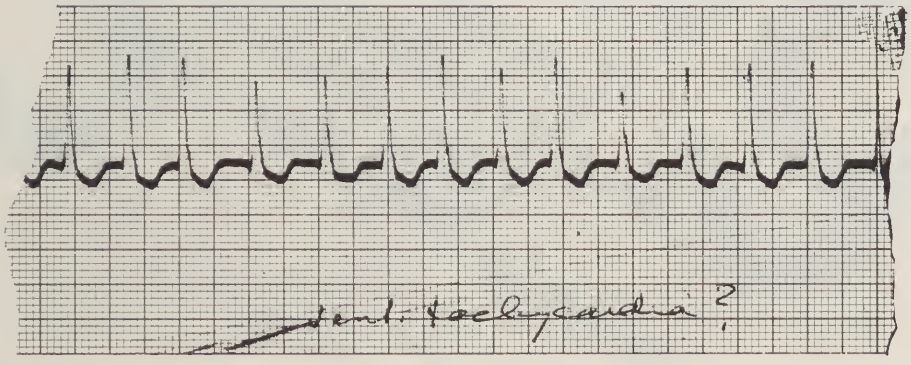

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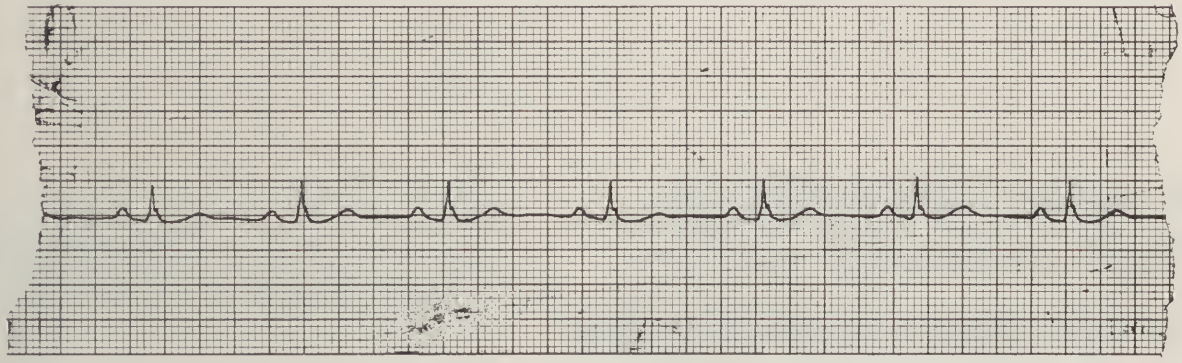
finding was a right central VII paresis. Blood pressure was 176/90; pulse 140-160/min.

The patient was slipping into deeper coma and was not responding to painful stimuli. He was taken to the operating room, with the visascope connected (Fig 3A). Bilateral subtemporal burr holes were placed and bilateral subdural hematomata evacuated. After the second trephine was

Fig 3



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3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneuratics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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made (on the left) the left side of the brain partially decompressed, the ECG and pulse reverted to normal (Fig 3B).

During surgery, the brain re-expanded rapidly, filling the space where the subdural hematomata had been evacuated.

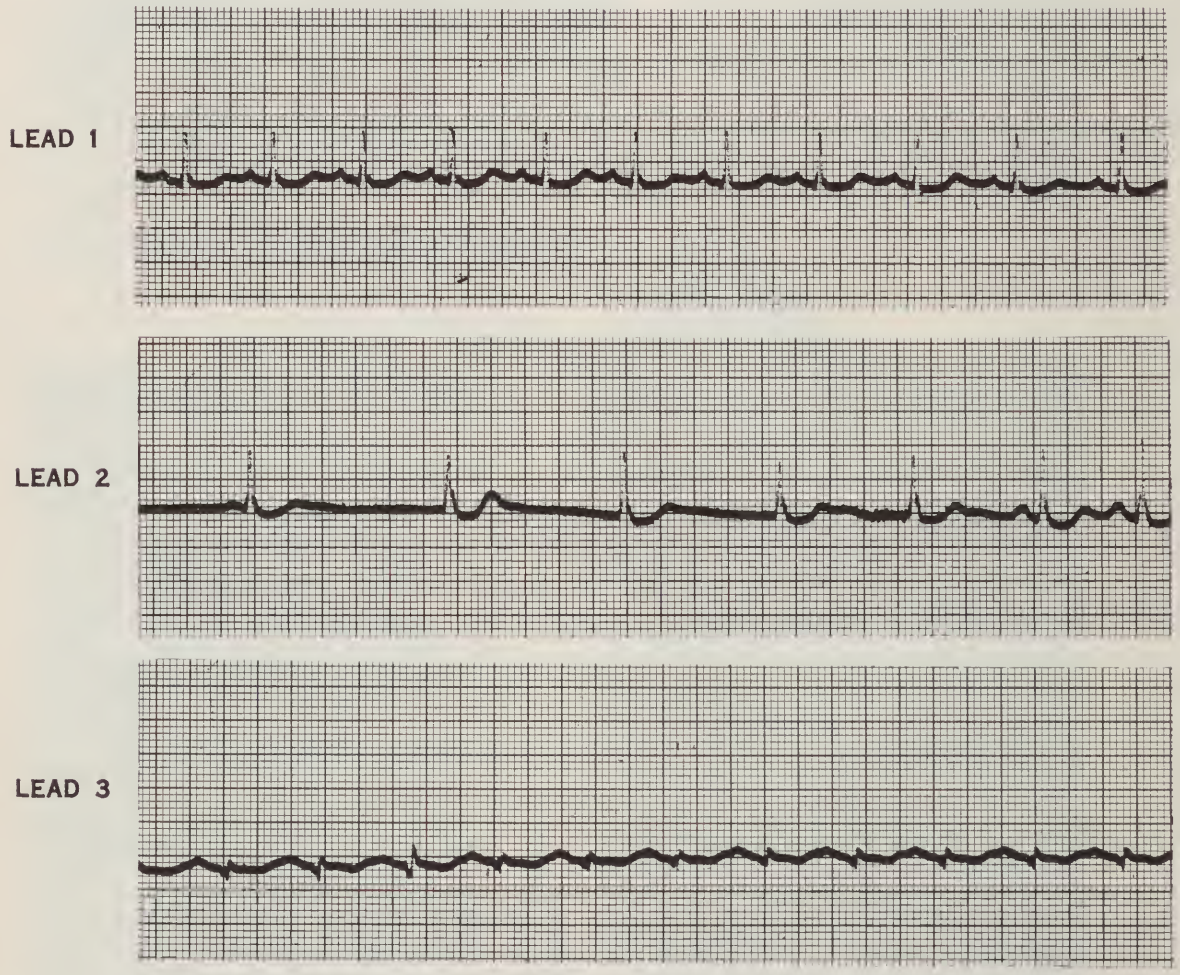
Digoxin, 0.5 mgm daily, was maintained postoperatively. The patient became more responsive and moved all extremities. The pulse rate was 80-100/min and regular for eight hours after surgery. It then became irregular. Figure 4 shows the postoperative electrocardiographic findings. Mercaptomerin sodium (Thiomerin) and mannitol improved the urinary output. The intravenous fluids were restricted to a minimum. Twenty hours after surgery the temperature rose to 103 rectally, and hypothermia was instituted.

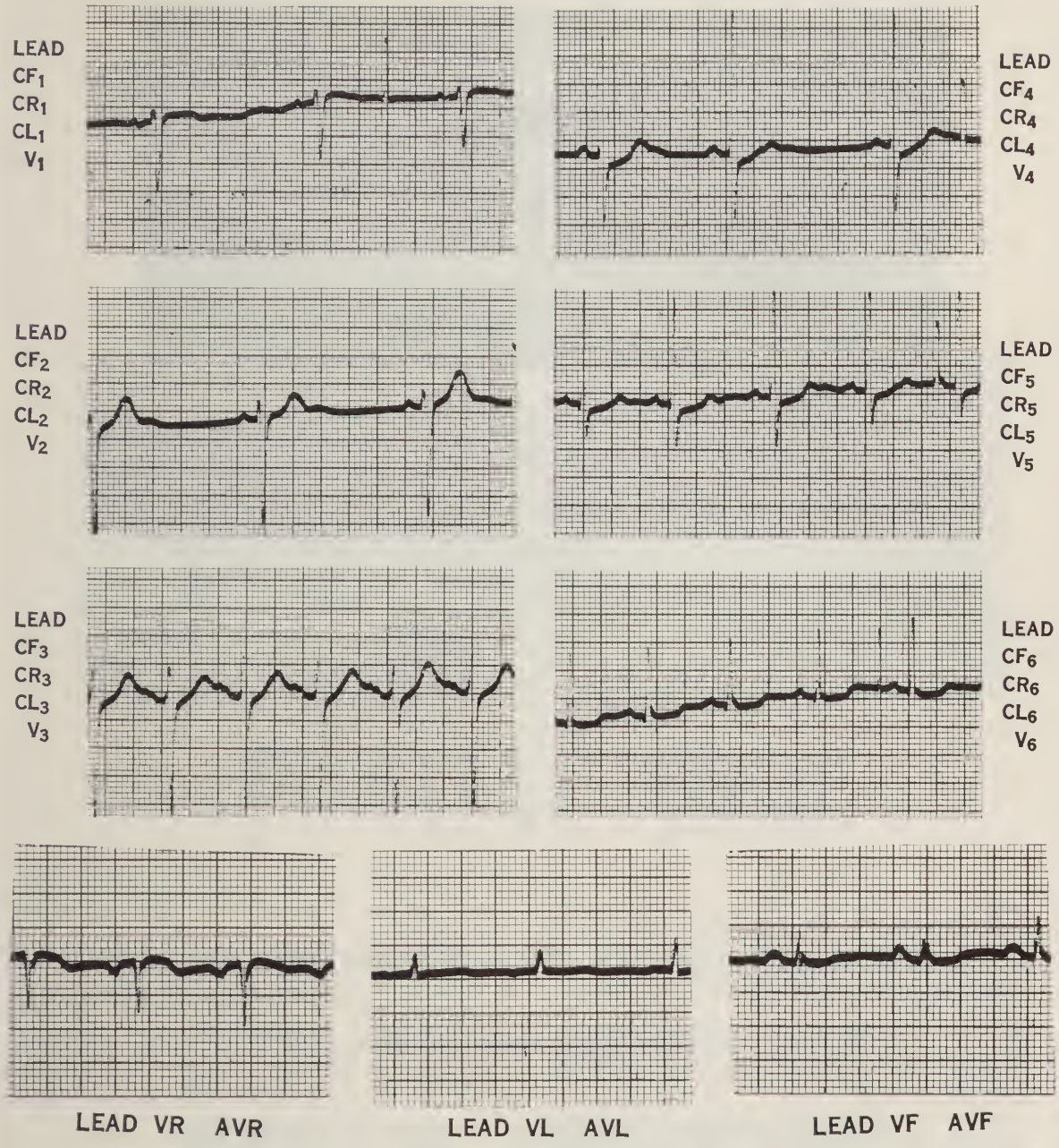
Electrolytes remained normal: BUN, 20%; SGOT, 25 units/ml; Hct, 45%, WBC, 13,900/cu mm. The patient regressed slowly into deep coma. Forty-eight hours after operation, there was definite spasticity of the left side. Cerebral needling through the right parieto-occipital burr hole evacuated 5 ml of blood. The patient continued to deteriorate with labored breathing. He died on the seventh day of hospitalization.

At autopsy were found the remnants of the subdural hematoma, subarachnoid hemorrhage, and a fresh intracerebral hematoma that measured 6-7 x 3-4 cm in the white matter of the right central and parietal lobe, extending from the cortex to the lateral angle of the sella media of the right lateral ventricle at the level of the lateral geniculate body. The brain was edematous and weighed 1650 gm. There was no compression of the midbrain.

The coronary arteries showed atherosclerosis with pinpoint lumen. The heart was enlarged and

Fig 4





weighed 500 gm. There was no evidence of recent or old myocardial infarction. The liver showed acute congestion and fatty metamorphosis.

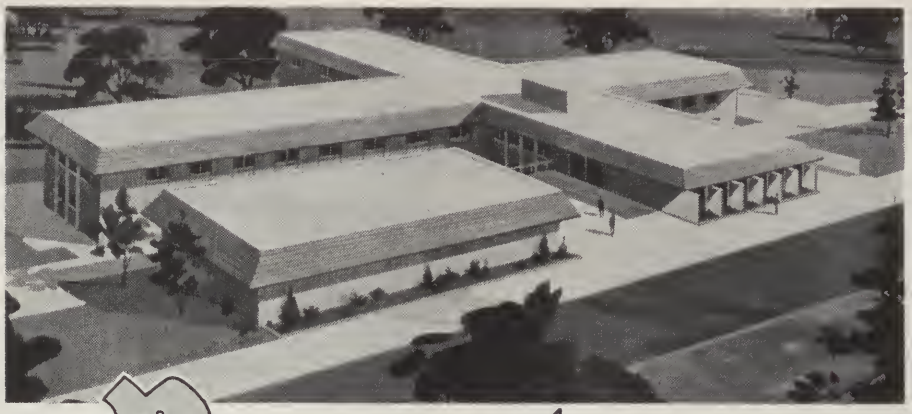
Conclusion

From review of the literature and from observations made on this patient, it would seem that cardiac arrhythmias may result from rapid increase in intracranial pressure rather than from specific brain damage. Subdural hematoma is presented in this case report as a specific cause of cardiac arrhythmia.

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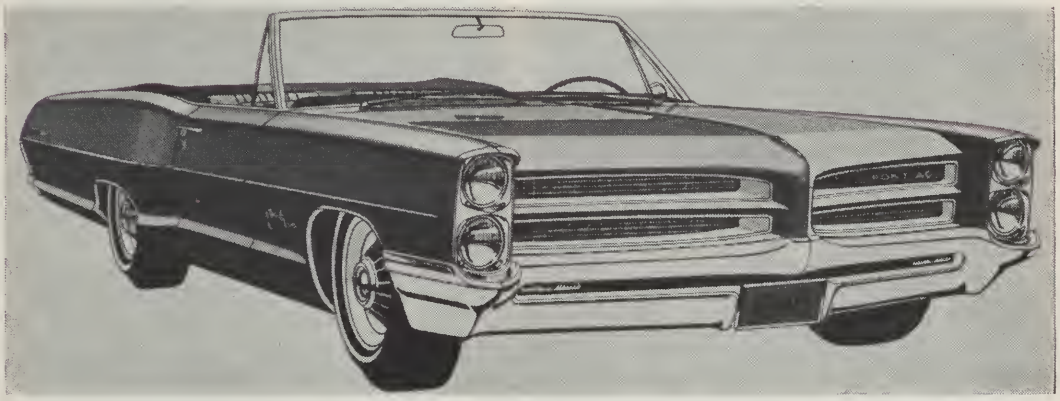
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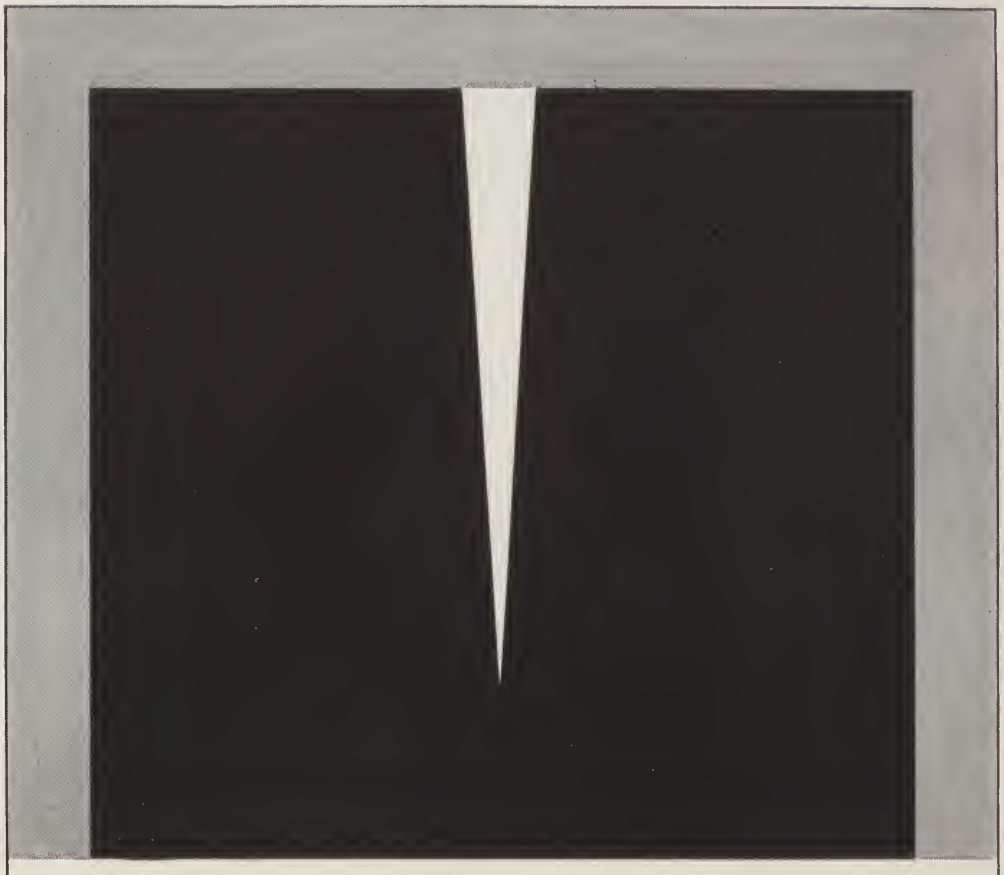
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SURGICAL REHABILITATION AFTER RADICAL MAXILLECTOMY AND ORBITAL EXENTERATION

JOHN E. HOOPES, MD
MILTON T. EDGERTON, MD

The extent to which an ablative technique reasonably may be applied depends upon the degree to which satisfactory function and acceptable appearance may be restored. Interference with function or alteration of appearance to a point that would preclude the patient's right to pursue a useful, meaningful existence violates the basic tenets of medicine. Reconstructive techniques have been highly refined, yet inadequate advantage has been taken of modern surgical methods to provide optimal management for patients with cancer of the head and neck.

Resection of the maxilla is a well established technique in the management of caner. In its limited form, the resection introduces relatively minor problems in reconstruction. When combined with more extensive resections, which require considerable sacrifice of soft tissue and the orbital contents, few procedures produce more devastating functional impairment or more grotesque deformity.

Five major areas of reconstruction must be dealth with. The goals are: 1) to obtain a healed wound, 2) to restore palatal competence, 3) to support the orbital contents, 4) to restore facial contour, and 5) to obliterate the facial defeat.

Initially, maxillary resection was associated with high morbidity. The large areas of exposed muscle and bone contaminated by oral secretions gave rise to repeated postoperative hemorrhages. Profuse drainage required meticulous nursing care with careful attention to frequent wound packing. Discomfort was considerable and prolonged, and marked deformity resulted from contracture and displacement of soft tissues.

Application of a skin graft to denuded areas provides the most expedient means of obtaining a clean, healed wound. The concept of immediate replacement of lining is a major advance toward reconstruction after maxillectomy. The skin graft is placed on the buccal surface of the cheek flap and sutured to the remaining mucosa with fine catgut. The entire pterygoid fossa and the undersurface of the globe, if necessary, are covered so

From the Division of Plastic Surgery, The Johns Hopkins Hospital and School of Medicine.

Refinements in reconstructive techniques allow a more thorough surgical approach to tumor extirpation by assuring satisfactory functional and cosmetic rehabilitation. Operative rather than prosthetic management of palatal defects is preferred and should precede closure of an orbitofacial defect. Forehead and cervical areas provide ideal pedicle flap tissue in terms of accessibility, rapidity of transfer, and quality of material.

as to leave no granulating surface other than the resection margin on the palate. The cavity is packed firmly with iodoform gauze saturated with balsam of Peru, care being taken to apply pressure and overcorrect the cheek. The packing is removed on the seventh postoperative day, and a temporary dental prosthesis is used to support a lighter pack for an additional week. The patient is comfortable throughout convalescence; healing is prompt and uncomplicated, allowing early toleration of a prosthesis; and deformity is minimal. This refinement overcame many of the problems associated with maxillectomy but left unresolved management of the palatal fistula and restoration of facial contour.

The functional disability caused by loss of the palate is tremendous, and restoration of palatal competence is mandatory. Having experience with both prosthetic and surgical closure we are convinced that repair with living tissue offers unequalled results in terms of comfort, speech, hygiene, and eating. Patients who have experienced both methods of management uniformly report surgical repair to be the more satisfactory. The impetus for repair has come from patients dissatisfied with prostheses.

Dental prostheses have a number of disadvantages: 1) there is difficulty in obtaining an adequate leak-tight seal without irritation; 2) retention is virtually impossible without adequate dentition; 3) the prosthesis impinges on mobile structures and gag areas; 4) frequent necessary replacement is prohibitively expensive; 5) all patients complain of discomfort, continued difficulty with speech, problems of oral hygiene, and a deep sense of personal deformity associated with daily care and wearing of the prosthesis.

Objections to surgical repair are proposed in terms of age of the patient, time and expense involved in staged procedures, creation of secondary deformity, and technical problems encountered in intra-oral wound healing. It is the elderly, edentulous patient who rarely obtains an acceptable result with a prosthesis. The magnitude of the palatal defect resulting from extensive resections prevents retention of any ordinary prosthesis. With proper planning, most of the reconstructive procedures can be performed under local anesthesia; brief periods of hospitalization are required for each procedure; and negligible secondary deformity is produced. The period of reconstruction is brief when compared to a lifelong commitment to an obturator. Much reluctance to pursue surgical rehabilitation stems from unfamiliarity with reconstructive techniques.

Local tissues in the form of palatal or buccal mucosal flaps are used to repair limited palatal fistulas. For larger defects, a generous cervical tube pedicle flap is most satisfactory. The reconstructed palate must be airtight. It must have adequate rigidity without excessive bulk. Two non-hair-bearing lining surfaces must be provided, and it must not interfere with the wearing of a denture. Cervical tissue satisfies these qualifications admirably.

The dimensions of the flap depend upon the location and size of the palatal defect. The flap is outlined transversely within the natural skin lines with the permanent pedicle located slightly below the angle of the mandible on the side of the defect. The donor area usually may be closed primarily but is grafted if necessary (Fig 1). Delay of the distal pedicle three weeks after the initial pro-

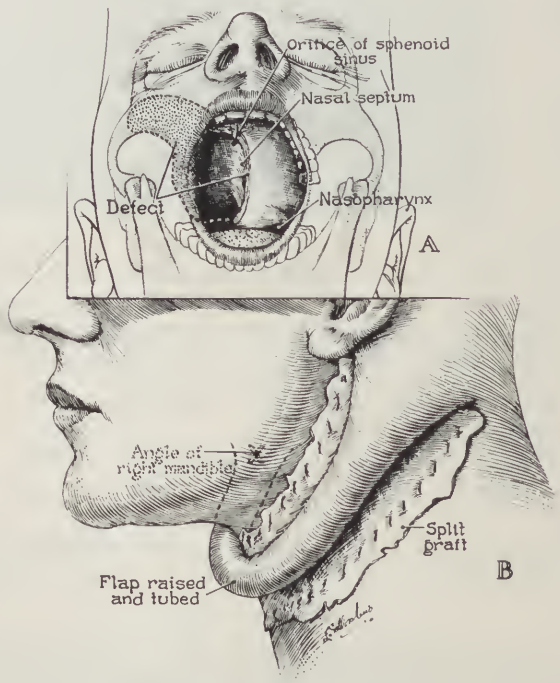


Fig 1

The usual deformity consists of a large palatal fistula and absence of bony support in the malar region. The bipedicle cervical flap is elevated within the natural skin lines and tubed. The donor area usually may be closed primarily.

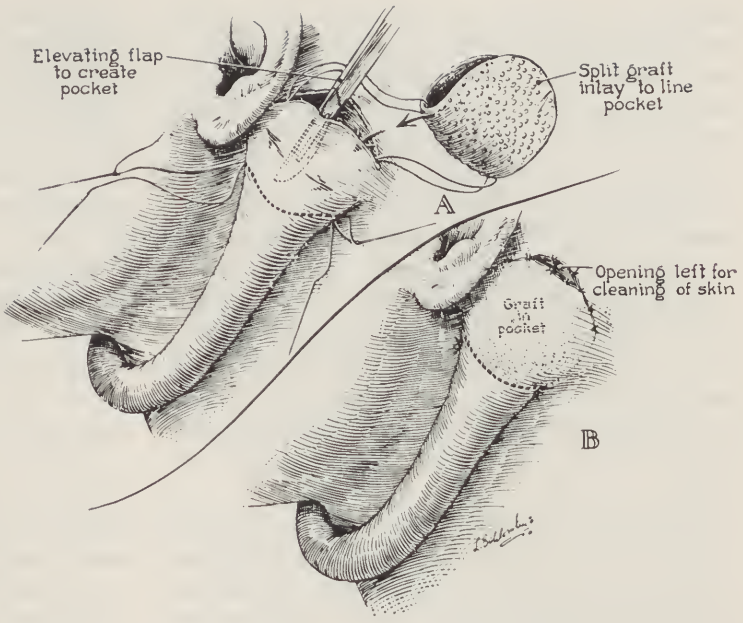


Fig 2

The distal pedicle is lined with a skin graft which will serve as nasal lining.

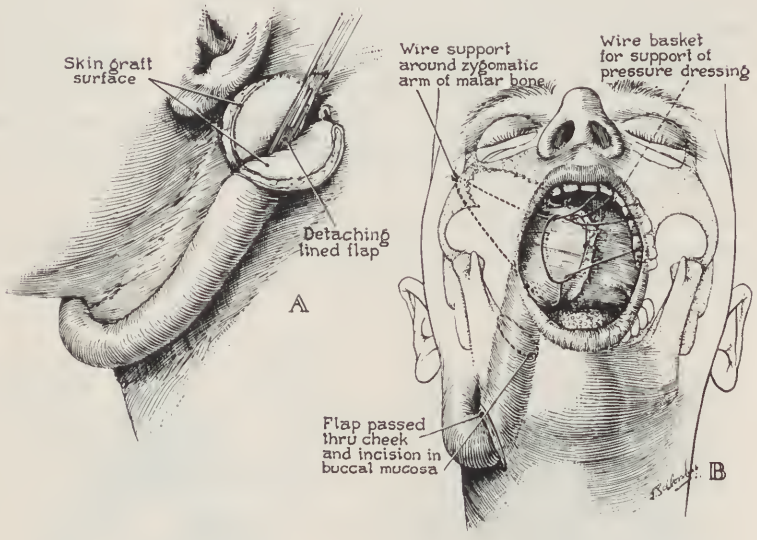


Fig 3

The distal pedicle is introduced into the buccal cavity through the submaxillary triangle on the medial aspect of the mandible and sutured into the palatal defect.

cedure consists of lining the pedicle with a skin graft which later serves as the nasal floor (Fig 2). The scar tissue incited by the grafting provides rigidity that is desirable in a reconstructed palate. Three weeks after delay, the distal pedicle is transferred into the mouth through the submaxillary triangle on the medial aspect of the mandible. Introduction of the flap through a submandibular incision avoids facial scarring and compromising the oral aperture. The recipient site for the flap is prepared by elevating mucoperiosteum, which is turned toward the margin of the defect, thus providing mucosal tissue for the attachment of the flap and increasing the area of attachment. The flap is contoured to the proper size and sutured into place in two layers (Fig 3). Proper support of the flap is essential. A wire basket is constructed within the superior alveolar arch and wired either to the teeth or directly to the alveolus. The basket permits packing to be inserted and held with moderate pressure against the implanted end of the flap. Nasal packing is

inserted above the flap. At the time of division of the pedicle, sufficient skin is preserved to create a sulcus between the reconstructed palate and the buccal mucosa. The total reconstruction is accomplished in four operative procedures over a period of eight to ten weeks. Complications in the form of infection and partial flap separation have occurred but never have been of sufficient magnitude to warrant abandoning the original plan.

Temporary use of a prosthesis is advisable if delayed reconstruction is planned. In this circumstance, preoperative dental consultation should be arranged for obtaining impressions and preparing existing teeth for retention of the prosthesis. Fewer than 5% of patients benefit by this approach.

Young patients tolerate reasonably well use of a flap from the medial aspect of the brachium. This method is preferred for palate reconstruction if cervical tissues are not available or if the defect is anteriorly and centrally located. Elderly patients may suffer permanent pain and disability in the upper extremity after immobilization.

Although the usual resection either retains the orbital floor or includes an orbital exenteration, occasionally the orbital floor is sacrificed but integrity of the orbital contents maintained. Binocular vision can be preserved only by providing adequate support for the globe. Immediate and permanent support may be provided either by a temporalis muscle-fascia flap transferred across the floor of the orbit to the medial margin of the bony resection or by a median forehead flap transposed inferior to the globe with the forehead skin directed into the antrum. Reconstitution of the orbital floor with a bone graft may be performed as a secondary, planned procedure if necessary.

Restoration of facial contour is as important as functional considerations and must be an integral step in rehabilitation. The method to be used is determined by the specific situation and the ingenuity of the surgeon. If a cervical flap has been employed to reconstitute the palate, the unused portion of the flap provides excellent contour material. The epithelium is carefully removed and the fat flap transposed subcutaneously into the area of the malar prominence (Fig 4). Dermis-fat grafts are suitable, but resorption occurs to a greater degree and they are less predictable than grafts with pedicled fat. The new synthetic materials appear promising for use in this area of reconstruction. Dental prostheses can be modeled to support the cheek and orbital contents.

Combined palatofacial defects extending from the brow to the lip, from the zygomatic arch to the midline of the nose, and looking directly down on the tongue and pharynx pose complex restorative problems. In our initial experience with such patients, obliteration of the orbitofacial defect was assumed to be the major surgical need, and a dental prosthesis was used for the palatal defect. Definitive reconstruction demands flap coverage. Tis-

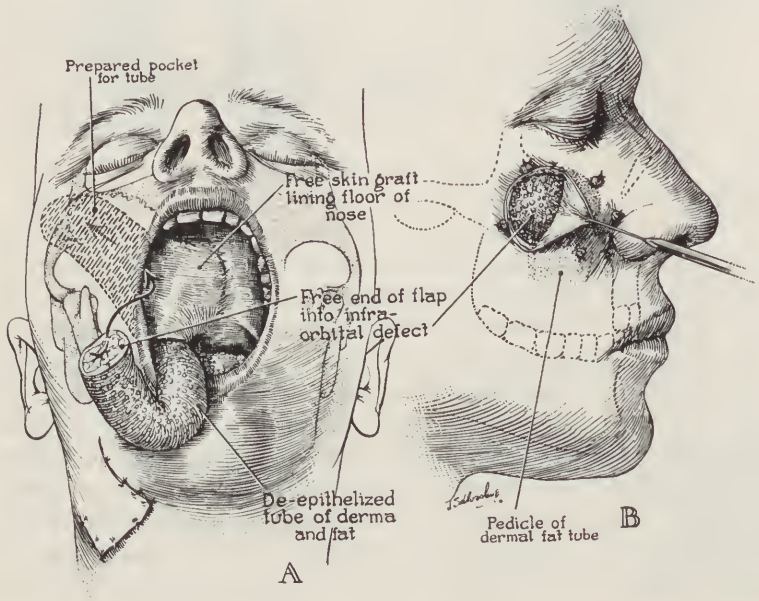


Fig 4

The denuded, excess portion of the cervical flap provides ideal contour material for correction of the cheek deformity.

sue pedicled about the head and neck has proved more satisfactory than distant tissues, and we have tended to rely on the scalp or cervicothoracic region for donor material. Preparation of these flaps includes application of a skin graft lining which will be sutured to the mucosal margins of the defect. Even though the wounds are massive and topographically complex, it often is possible and practical to obtain a healed wound by careful application of a skin graft, thereby allowing somewhat more deliberation in securing pedicle flap coverage.

It is surprising that most patients are content to disguise the residual deformity with either a frosted lens or a black patch. An occasional patient will benefit from the excellent facial prostheses now available.

Experience has shown that restoration of palatal competence is of primary importance and should precede obliteration of the orbitofacial defect. On this basis, we have sought methods of accomplishing repair in both areas with a minimal number of procedures.

The hinged nasal septum flap provides an expedient means of reconstituting the palate. After resection, the margins of the palatal defect are permitted to heal completely so that adequate mucosal circulation is reestablished on the side of the defect. Three to four weeks after resection, the cheek incision is reopened to provide access to the nasal septum and palatal defect. The palatal defect is reproduced on the septum with the base of the flap on the vomer. The entire thickness of the septum is incised down to the junction of the septum with the remnant palate. The septal flap is bent over to the side of the defect until the cartilage dislocates from its nasal crest articulation and the vomer fractures in its caudal portion. Appropriate mucosal flaps are elevated about the perimeter of the palatal defect to receive the margin of the septal flap so that a double-layered closure can be accomplished (Fig 5). The procedure has the obvious advantages of being accomplished in one stage and of providing a thin, rigid palate. It has become our procedure of choice for restoration of hemipalatal defects. A lined forehead flap to the orbitofacial defect completes the reconstruction. We have encountered no functional problems referable to loss of the nasal partition.

The total forehead flap lined with a skin graft may be used for total reconstruction. In terms of color, lack of hair, accessibility, and texture and body which give it supporting quality, the forehead flap provides an ideal tissue for this purpose. In view of the almost perfect color match provided

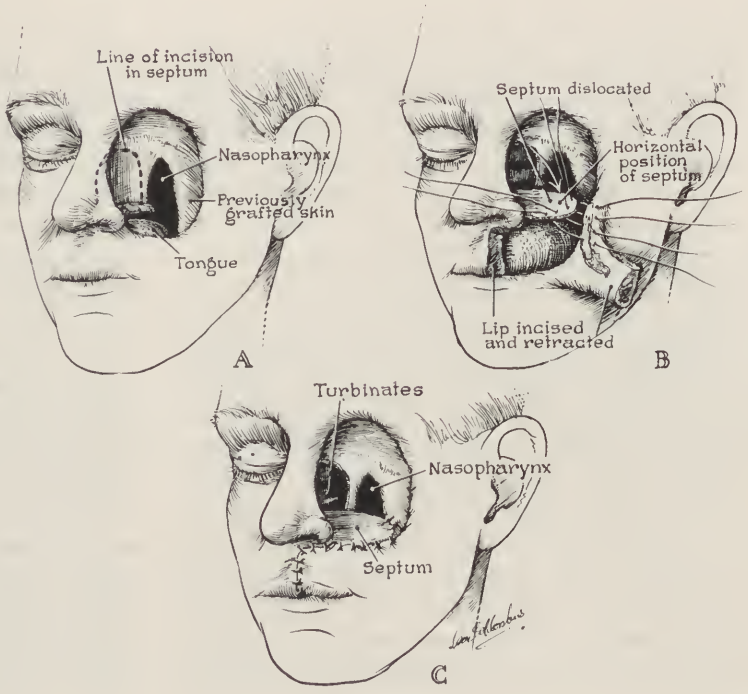


Fig 5

The hinged nasal septum flap is the preferred method for restoration of hemi-palatal defects. Obliteration of the orbitofacial defect is accomplished with a lined forehead flap.

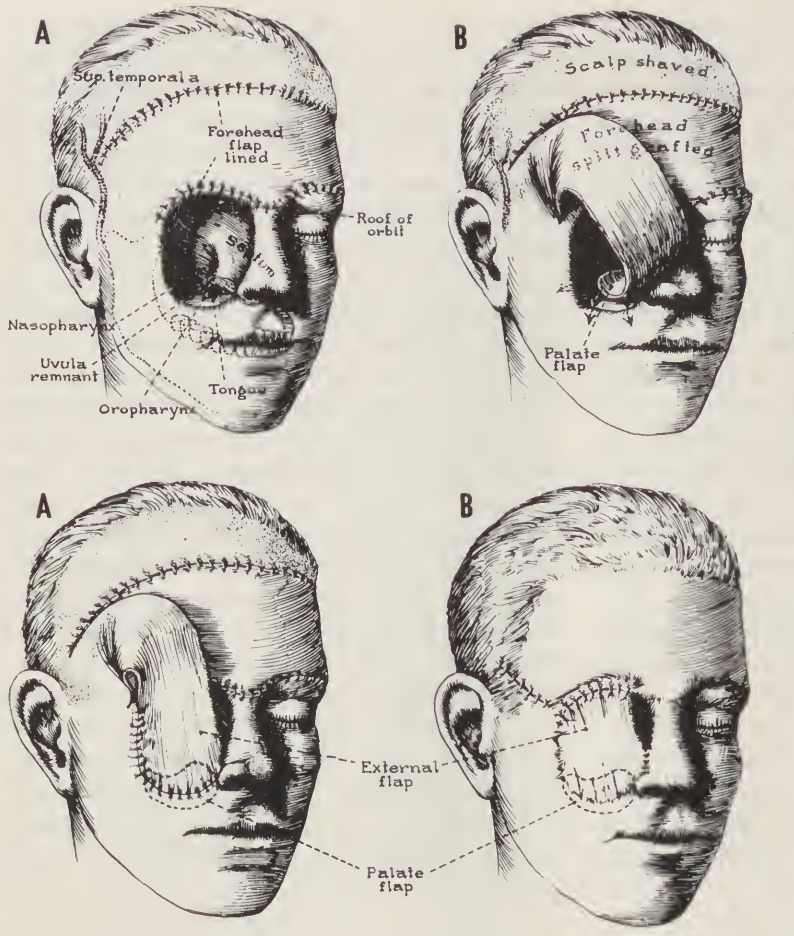


Fig 6

A total forehead flap based on the ipsilateral temporal artery and lined with a skin graft provides an expedient method for restoring palatal competence and obliterating the orbitofacial defect.

by a skin graft obtained from the neck or clavicular area, we have no reservations about using the total forehead as flap donor tissue. A bipedicle flap of the forehead is elevated down to frontalis from ear to ear and from hairline to brow with preservation of both temporal arteries. The flap is lined with a skin graft and returned. Ten days later, the contralateral pedicle is divided on a line with the lateral canthus and the distal end of the flap passed through the orbitofacial defect and approximated to the margins of the palatal defect with the forehead skin directed orally. Suturing to the lip requires removal of a strip of forehead skin epithelium. The flap is supported with the wire basket described previously. The forehead is grafted with a split thickness graft from the neck or clavicular area. The skin graft is applied as a single unit extending from hairline to brow and from lateral canthus to lateral canthus. Three to five weeks later, the temporal pedicle is divided and the remaining flap used for partial or complete obliteration of the orbitofacial defect (Fig 6). Partial obliteration with preservation of a "window" for follow-up evaluation frequently is preferred to complete closure. The entire reconstruction requires only one additional procedure and three weeks longer than simple obliteration of the cheek defect.

The question of timing must be weighed carefully. Proponents of delayed reconstruction argue that the patient should not be submitted to a series of "needless" operations without assurance of cure and that reconstruction masks recurrence. What constitutes a reasonable period of observation is open to considerable question. Basal cell carcinoma and melanoma may recur many years after initial therapy. Although most epidermoid carcinomas which recur do so with in one year, even a three-year period free of disease is no guarantee of cure.

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the psychological and general physical deterioration consequent to a radically destructive procedure which precludes normal function? Only rarely will reconstruction conceal a recurrence and deceive the meticulous examiner. Performance of multiple biopsies during a series of reconstructive procedures often has disclosed clinically unsuspected recurrence which has yielded to further surgery. Patients who develop recurrence in nonresectable areas obtain considerable dividends from immediate reconstruction.

Flap preparation at the time of resection saves time. In the usual case, construction of a cervical or forehead flap is performed in conjuction with the extirpative procedure. The occasional patient will be managed most efficiently by flap preparation before resection. Delayed reconstruction is reserved for selected patients with anaplastic tumors in whom further removal of tissue would be possible and in whom the functional and cosmetic deficit is compatible with a happy, useful existence.

The extent to which reconstruction is pursued is governed by the patient's desires and the surgeon's ability to achieve further improvement. The *effective* degree of cosmetic deformity must be appraised carefully; the limitations of plastic surgery must be realized. Reconstruction should always be planned and often initiated at the time of tumor resection.

The Johns Hopkins Hospital
Baltimore, Md 21205

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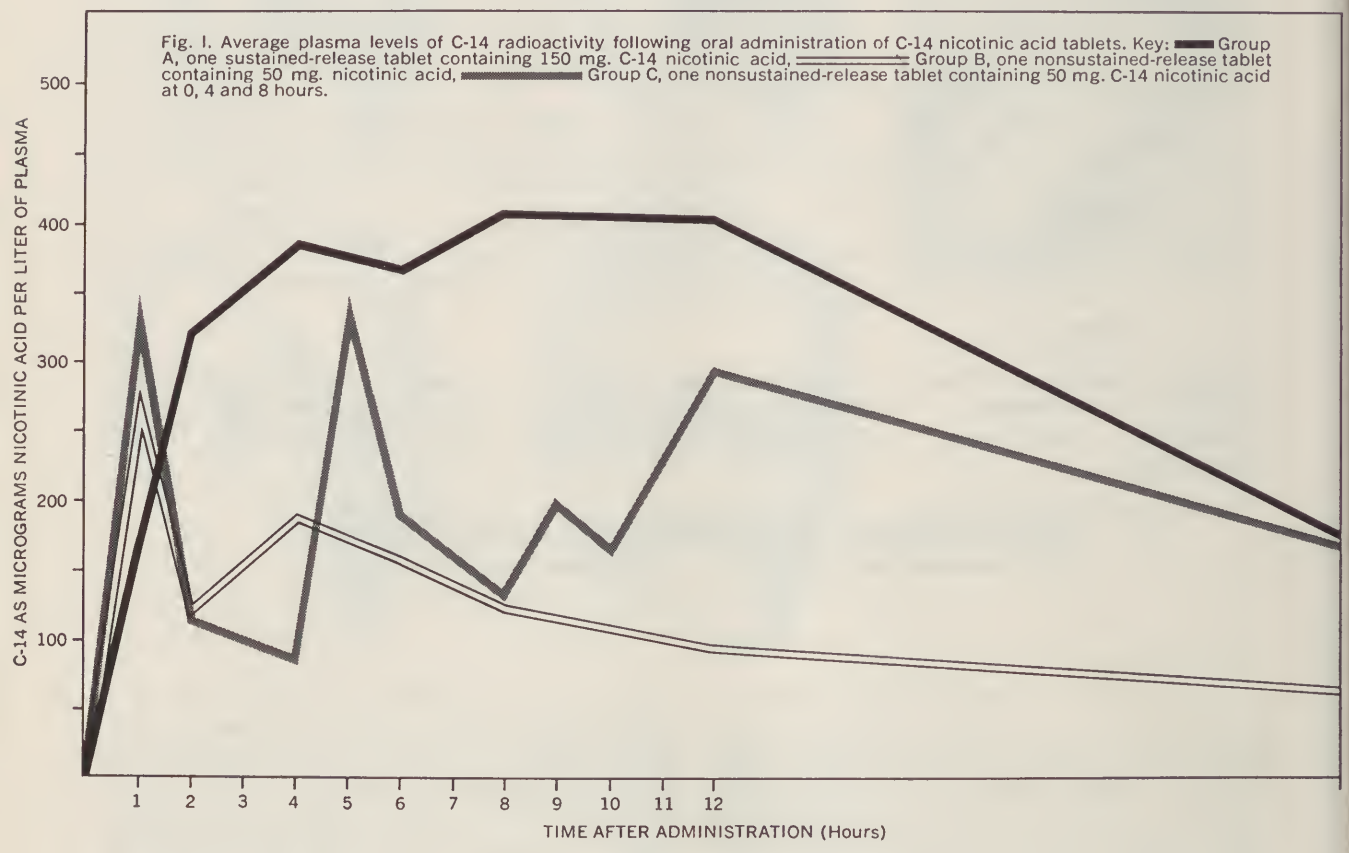


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



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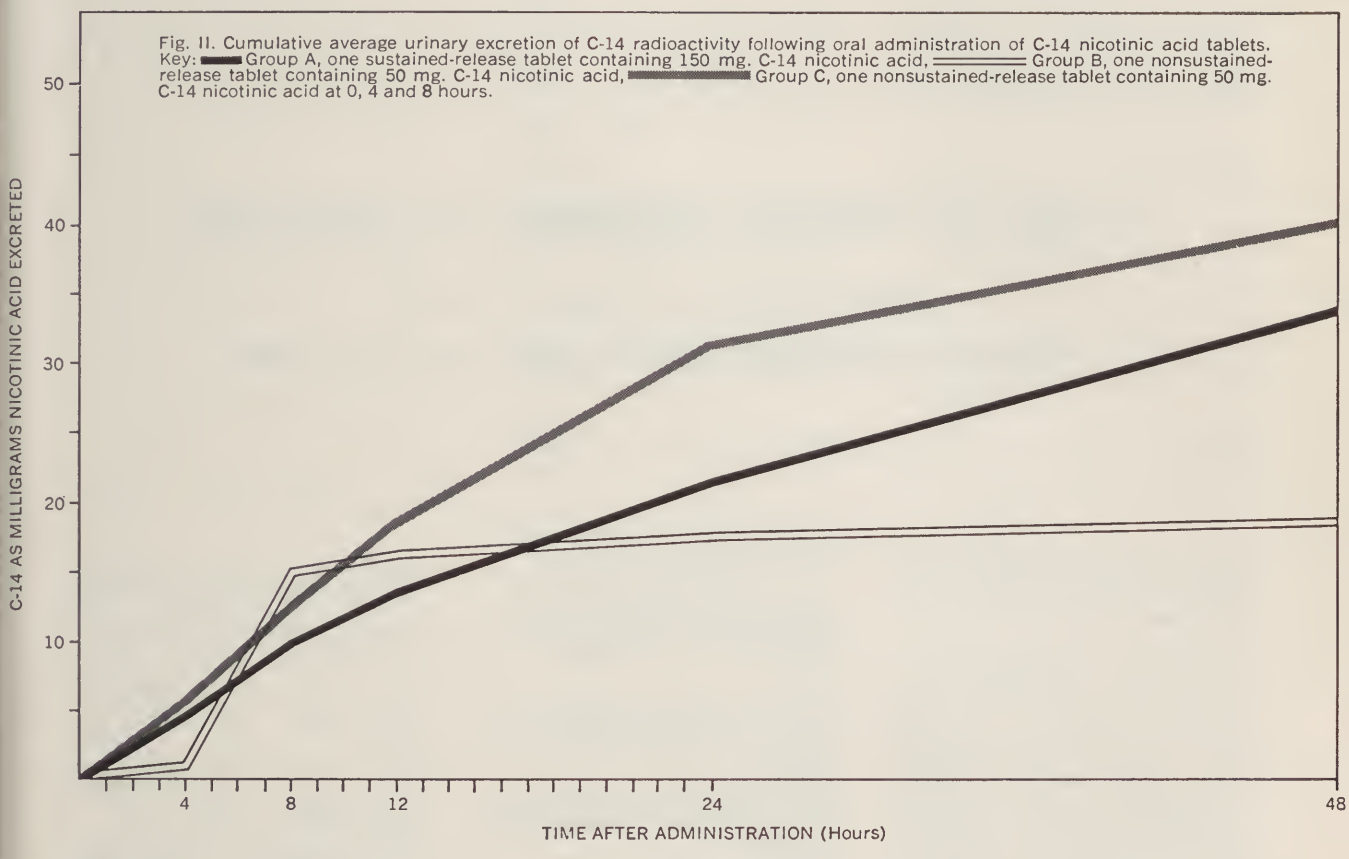
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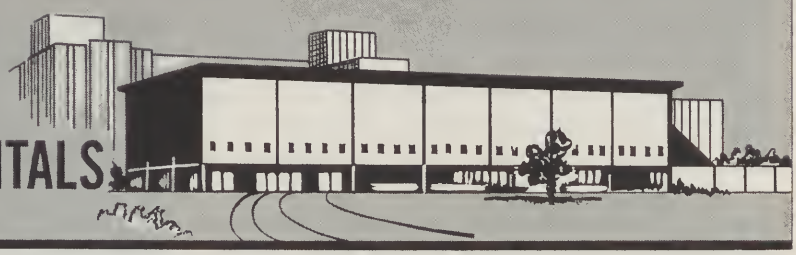
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HISTORY OF THE BALTIMORE CITY HOSPITALS

BY DOUGLAS CARROLL, M.D.



Chapter 9.—The Baltimore City Hospitals Under the Department of Public Welfare: Social Change (1935-1955)

So have attitudes toward medical care shifted over the centuries: from a "blessed benevolence" or a "private luxury," medical care has gradually assumed the status of a necessity and a "civic right." The speed and degree of the most recent change have been so great that we may be said to be living in a veritable "revolution of rising expectations" in regard to health and medical care.[1]

This period started with the Great Depression, with its mass of unemployed patients on welfare. It progressed through the Second World War and ended in a period of unusual prosperity. Under the Department of Public Welfare, administrative procedures improved efficiency. More significant was the growing acceptance of the idea that the poor and unemployed had certain rights due them from the state and were not mere subjects of benevolent paternalistic private charity.[1]

At the beginning of the period, the new Acute Hospital, the north section of the B Building, and the new Nurses' Home were put into operation. The new Tuberculosis Sanitarium was completed in 1937. During World War II and thereafter all services deteriorated. Toward the end of this 20-year period, it became obvious that all services would have to be headed by full-time chiefs, that renovation of the Almshouse would be required, and that additions to the General Hospital were essential.

A number of men influenced this era in the hospital's history. Dr. George Walker, a urologist in private practice in Baltimore and a member of the Board of Trustees foresaw the need for an acute general hospital. It was his vision which resulted in the building of the present Acute Hospital. Dr. Walker was also instrumental in having the Baltimore City Hospitals placed in the Welfare Department and, along with Dr. Alan Chesney, in cementing the relationship with the medical schools.

Another man influencing the hospital during this period was Mr. Thomas J. S. Waxter (1898-1962), who was the first director of the Baltimore City Department of Public Welfare. He was particularly concerned that the hospital render excellent care to the indigent of Baltimore. He was ably assisted by Mr. Francis Davis of the Board of the Department of Public Welfare. The hospital was fortunate in obtaining as superintendent Mr. Parker J. McMillin, who directed the hospital throughout this period and retired in April, 1959.

The new Acute Hospital (present A Building) was opened March 1, 1935. The building was in form of an E, and it contained the obstetrical, surgical, medical and pediatric services. The operating rooms were on the top (fifth) floor. Administrative offices, the emergency room, laboratories, the pharmacy, the Department of Pathology, and x-ray were on the lower floors. Each clinical service was laid out on a single floor with 100 beds.

In 1935, the north section of the Chronic Hospital (present north section of the B Building) was opened. The chronic neurological ward, a chronic orthopedic ward, and chronic medical and surgical wards were located in this section.

During the next few years, applications for housestaff positions exceeded anything which had ever occurred before. The Medical Advisory Board met monthly and made numerous recommendations to the Department of Public Welfare.

WPA labor was used for several years to renovate and recondition the Infirmary and other buildings of the hospital. The farming operation consisted of a large truck farm and a dairy herd of 70 milk cows with two bulls. In 1937, after the extensive building and renovation, all patients were housed in reconditioned or new buildings. No further major changes in buildings occurred until the addition of the Outpatient Department in 1950, the building of the new Tuberculosis Sanitarium in 1954, and the renovation of the Infirmary in 1959.

Hospital costs gradually increased and were ascribed to the development of modern facilities, the decreasing number of people admitted able to perform work, and the gradual improvement in the standard of service and medical care.

In 1937, Dr. Frank Kendall, who for many years had been resident in pathology in the Johns Hopkins Hospital, became pathologist-in-chief at the Baltimore City Hospitals, the first full-time chief of a service. On September 1, 1936, Dr. Thomas R. Boggs, physician-in-chief since 1911, died and was succeeded by Dr. John T. King. In 1939, Dr. Arthur M. Shipley resigned as chief of Surgical Service and was replaced by Dr. Thomas B. Aycock. In 1940, through the efforts of Dr. John T. King, the United States Public Health Service established a research unit of the newly formed Department of Gerontology under Dr. Edward J. Stieglitz. This new unit was to study the problems of aging and, over the years, has gradually increased in importance and flourished under Dr. Nathan Shock. In 1943, the Psychiatric Service was discontinued at the Baltimore City Hospitals and was taken over by the State of Maryland. In 1948, all farming operations were discontinued.

World War II brought on tremendous problems for the hospitals. The number of visiting physicians and housestaff dwindled. The Pediatric Service was closed, and admission to the Obstetrical Division was restricted. Red Cross nurse's aides, Grey Ladies, and home nursing and dietitian aides helped fill the gaps in the nursing



A cup awarded to the Baltimore City Hospital dairy herd in 1945. All farming operations (started in 1866) were discontinued in 1948, thus ending the workhouse function of the Almshouse.

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service. In 1946, the personnel deficiency was at its worse. German prisoners and conscientious objectors, who had previously been working in the hospital, were withdrawn at the end of the war. The shortage of nurses was met to some extent by the graduates from the School of Practical Nursing.

The hospital had by no means recovered from the deterioration of World War II when the Korean conflict took place. Toward the end of this period, it became clear that the serious personnel shortages could not be met by methods used in the past. Although the shortage of doctors was serious, Dr. Holmes Boyd and Dr. Otto Brantigan carried on excellent services as chiefs of medicine and surgery, respectively. In 1945, Dr. Harold Harrison was selected as full-time chief of pediatrics; Dr. Frederick Mandeville, as full time chief of X-ray Department; and Dr. Gardner Warner, chief of pathology. It became obvious that the most effective operation of the hospital would require that each department be headed by a full-time man. In the fall of 1952, Dr. George Mirick became the first full-time chief of medical service. In 1948, an eight million dollar bond issue had been passed by the people of Baltimore to construct a new tuberculosis unit and to renovate the Infirmary. As the new buildings became available and the number of full-time chiefs of service increased, the overall operation of the hospital improved radically.

After the great depression of 1929, a major change occurred in the attitude of the City toward the sick poor. At first, attempts were made to give relief through private charities, local municipal government, and the State; but finally the need for federal aid became clear. The belief that unemployment was not the fault of the individual was now clearly accepted.

Looking back, in 1952, on the work of the Department of Public Welfare of Baltimore, Mr. Thomas J. S. Waxter, director of the department, pointed out that the principle of assistance to the disabled and partially disabled was not new in the 1930's, but the volume and methods started in these years of depression were new and not completely accepted by all segments of American voters.

> Probably public assistance is now, insofar as public attitude is concerned, in the same position as the public health movement and the public school movement years past, before they had become generally accepted.
>
> Against this newness and the American attitude of giving short shrift to failures and a small hard core of people, who resent change of any kind, it has been difficult for those of us who believe in public assistance to gain the kind of approval for the public assistance program, which the public health authorities, the schools and such agencies as the public library enjoy. The beneficiaries of the public assistance program are the most handicapped and the least vocal group in the community.[2]

A second great force changing attitudes toward the poor was the pervasive influence of Sigmund Freud. He preached that there were hidden and uncontrolled instincts in all people, rich and poor alike, which, when exaggerated, led to certain mental illnesses. All people were in the grip of potentially disruptive forces. Health passed imperceptibly into sickness and virtue into sin. Therefore, all men were vulnerable to mental illness, irrational behavior, and depravity.

Furthermore, Freud's method was that of listening to people, accepting them as they were, and taking them seriously. His attempt to take the time to understand others was a measure of belief in the dignity and freedom of other individuals, no matter how perverse.

The depression helped men to see poverty as the result of circumstances beyond the control of the individual. Freud helped men to see that all men are vulnerable yet are capable of recovery. Thus, public welfare became acceptable treatment for those unable to care for themselves. Welfare services administered justly under federal, state, and municipal law became the order of the day.

The founding of the Department of Welfare and its direction under trained professional workers interested in the poor added tremendously to the effectiveness and understanding with which the sick were cared for. In the combined report for the years 1954 and 1955, Miss Esther Lazarus, who had replaced Mr. Thomas Waxter as director of the Department of Public Welfare, noted some of the changes made in the 20 years since the founding of the department in 1935.

> Until the 1930's, society here and elsewhere accepted and operated on the assumption that there must be something fundamentally wrong with the individual in need. We viewed as different in kind and quality from the rest of the population the clients of social agencies, and we invested these persons with certain unique defects and weaknesses. The Depression proved this atti-



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tude to be untrue. As economic breakdown unfolded and enveloped millions, depriving them of the opportunity to meet their basic needs for living, we began to recognize the forces operated in an industrial society which were beyond the control of any individual.[3]

She noted the shift in emphasis from *problems* and procedures designed to meet crises to emphasis on *people affected* by problems and on protective and preventive services. She noted that the Social Security Act, passed in 1935, marked a major milestone in the development of the country's philosophy of social welfare.

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In the care of children who became the responsibility of the Department of Public Welfare, every effort was made to nourish any spark of family life that might allow the child to remain with his parents while under the supervision of the department.

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ANNE ARUNDEL COUNTY

Our fifth annual banquet and dance was held June 4 at the Annapolis Roads Country Club. It was the biggest and best yet.

Among the guests of the Society were the administrators of Anne Arundel County's two hospitals, and their wives.

Cocktails and a buffet supper were served. During the dancing intermission, several talented members of the Society entertained. **Drs. Antonio Rivera** and **Max Frank,** our Spanish linguists, sang some Latin songs. A clever skit humorously depicted the new cardiac unit at the Anne Arundel General Hospital. **Drs. Gerry Church** and **Bill Wallop** sung "Medicare Blues" to the tune of "Wouldn't It Be Loverly."

MEDICARE BLUES
(Lyrics by Church and Wallop)

We're very sad this year,
We feel we're filled up with despair,
The President wants to open up a plan called Medicare,
To all of us this plan seems bad and anything but fair,
Oh, oh, wouldn't it be loverly.

—1—

All we want is to work somewhere
Far away from the Medicare,
Where we won't tear out our hair,
Oh, wouldn't it be loverly.

—2—

No King-Anderson or such health bill,
No more forms for us to fill,
We'd simply use our skill,
Oh, wouldn't it be loverly.

—3—

Oh so loverly being away from Lyndon B.,
We could have our very own new greater society.

—4—

No new frontiers for you and me,
Hubert Humphrey we'd never see,
We would have an honest fee,
Oh, wouldn't it be loverly.

(repeat 1)

Music for the entertainment was provided by Drs. **Richard Hochman, Gerry Church, Henry**

Holtgrewe, and **Stephen Hiltabidle** (on the washtub). All of the performers were accorded lusty cheers from the members, their wives, and their guests.

Samuel Borssuck, MD

WASHINGTON COUNTY

New Physician in Community

We welcome **Rizalito A. Amarillo, MD,** to our community. He opened his office at 120 Main Street, Sharpsburg. Dr. Amarillo attended high school, college, and medical school in the Philippines. He served his internship and a residency in pathology at the Brooklyn Jewish Hospital in New York. He also served a residency in general practice at the Cabell Huntington Hospital, Huntington, WVa; at the North Charles General Hospital, in Baltimore; and at the Huey P. Long Charity Hospital, Pineville, La.

Dr. Amarillo was in private practice in the Philippines from 1961-64, was house physician in surgery at Marymount Hospital, Garfield Heights, Ohio, from 1964-65, and junior staff physician at the Lynchburg Training School and Hospital, Colony, Va., from 1965 until May, 1966.

The Amarillos are making their home in Sharpsburg.

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Health Fair

The Washington County Medical Society will again participate in the health fair to be held in Hagerstown in November. **John J. Donoghue, MD,** is working on plans through the Public Relations Committee of the medical society. Details will be announced later.

The health fair will coincide with Community Health Week, sponsored by the American Medical Association.

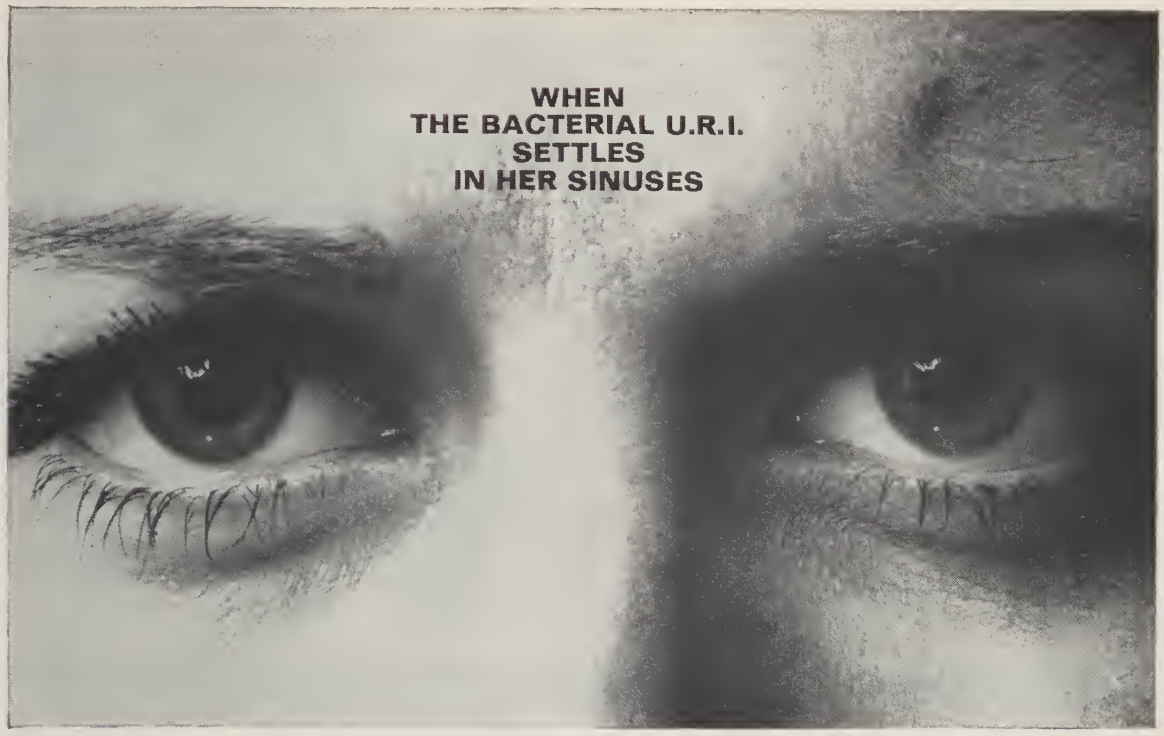
Richard A. Young, MD, was chairman of the first health fair, held last year. The medical society's exhibit included a demonstration of anatomy, using a mannequin, as well as free urine testing for diabetes, managed by our Woman's Auxiliary.

* * * * *

John C. Stauffer, MD, returned recently from Africa, where he took part in a project sponsored by Operations Cross Roads Africa, a non-profit organization similar to HOPE, in cooperation with the Nigerian government's Ministry of Health. Dr. Stauffer was located at a new general hospital (about 300 beds) in the eastern district of Nigeria, in a town called Enugu. He was there from June 26 through August 26. There is no remuneration for the physicians who take part in this project.

Our president, **Richard A. Young, MD,** had the honor of having his picture appear in a recent copy of the *AMA News.* Dr. Young, one of 13 recipients of the 1965 physicians awards for outstanding community service, was the guest of E. Claiborne Robins, president of the A. H. Robins Co., which sponsors the awards. The affair was held in Richmond in May. It was attended by the 13 physicians who had received the awards.

John W. Clark, MD, DDS



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Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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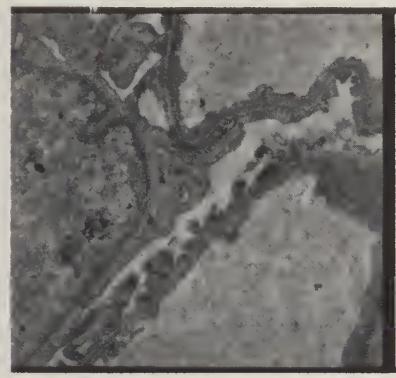
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AMNIOCENTESIS IN ERYTHROBLASTOSIS FETALIS

W. BRADLEY KING, JR., MD

A number of reports have appeared in recent years on the examination of amniotic fluid in pregnancies in which the development of erythroblastosis is possible. Because the principal problem of the erythroblastotic fetus is severe anemia with subsequent cardiac failure, it is important to know what the effect of sensitization on the fetus has been during the last part of pregnancy. One can then decide whether to carry out fetal intraperitoneal transfusions or to deliver the baby at the best time for survival.

Techniques have been developed to determine levels of bilirubin-like substances in the amniotic fluid. Bevis[1] showed that the amniotic fluid of erythroblastotic fetuses contained an increased quantity of blood pigments, which he believed gave an indication of increased hemolysis. Although the pigment is presumed to be bilirubin, its exact chemical composition is unknown.[4] Subsequent reports have correlated the severity of the hemolytic disease in the fetus with the level of these bilirubin-like substances.

The amniotic fluid specimens are obtained by a transabdominal approach into the amniotic sac (usually near the fetal neck). The specimen is then placed in a dark, stoppered bottle and sent to the clinical laboratory for determination of the bilirubin-like substances.

Since the aspiration of blood or bloody fluid immediately introduces a complication (for it may be from the mother's abdominal or uterine walls, placenta, fetus, or umbilical cord), it is necessary to determine whether the erythrocytes present are maternal or fetal or both. This can be done by the Kleihauer-Betke stain.*[2] The same problem exists if bloody fluid is aspirated from the amniotic sac.

Amniocentesis in patients *known* to be sensitized may be performed as a single determination[3] or as a pair of determinations: if single, at about 32 weeks; if double, the first between 29-32 weeks and the second about two to four weeks later. The purpose of the two determinations is to detect any change in the rate or degree of hemolysis, as manifested in the level of the bilirubin-like substances in the amniotic fluid (Fig 1).

*In alcohol-fixed smears of the bloody fluid, when the smears are then treated with a citric acid-phosphate buffer solution, of pH 3.4 - 3.6, at 37°C, the adult RBC lose their hemoglobin and become shadow forms, whereas the fetal RBC retain their hemoglobin and are still readily visible on the smears.

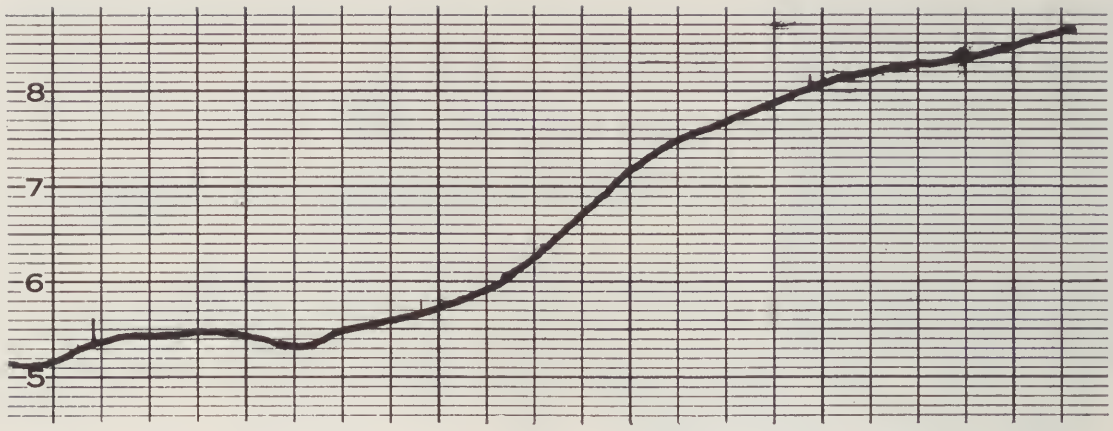


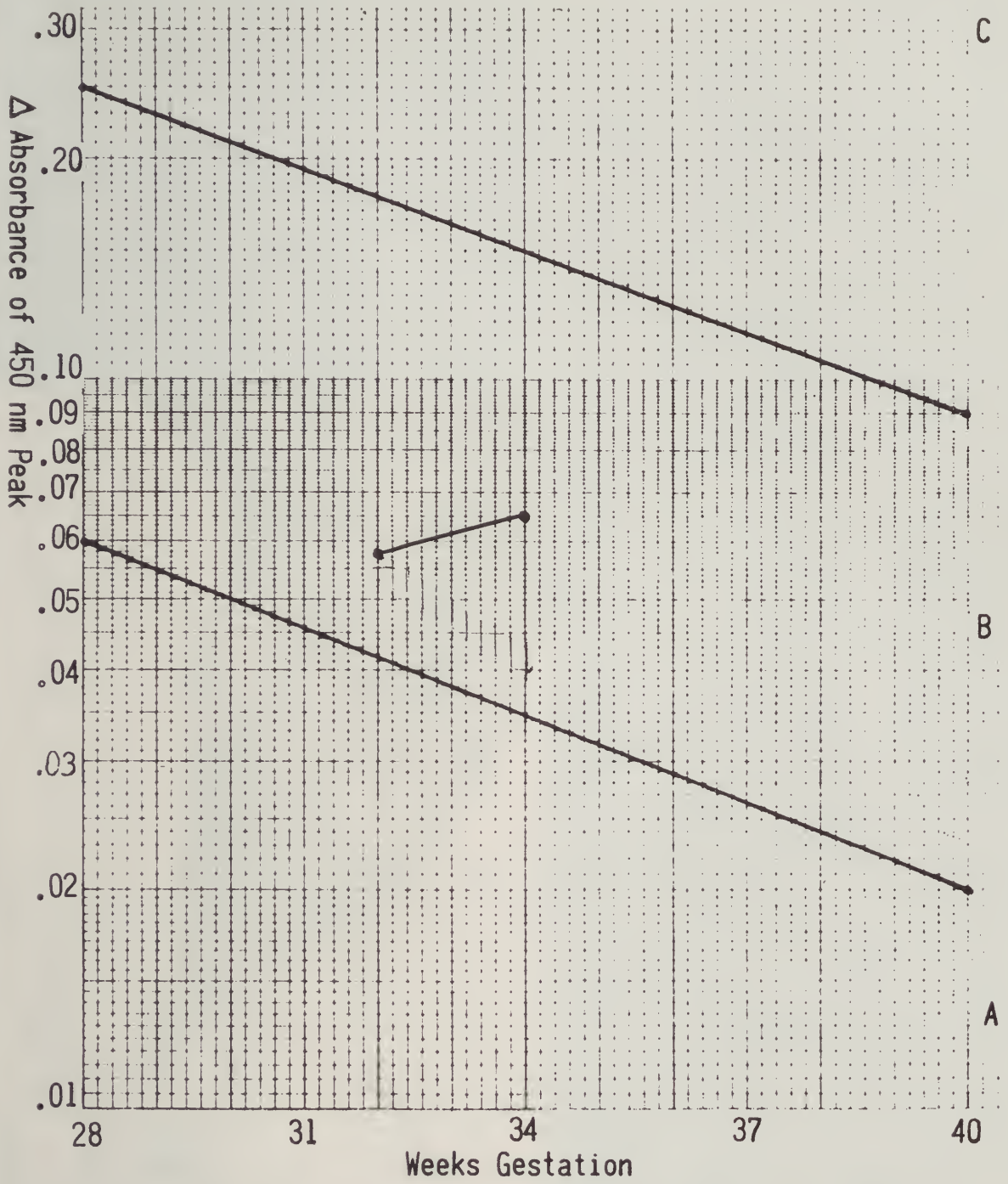
Fig 1 Fig 2 →

The level of these bilirubin-like substances is determined with a spectrophotometer set at 450 mμ. Liley[4] considers centrifugation (30 min at 3,000 rpm) of the specimen adequate in most cases, but if the fluid remains turbid, filtration with Whatman #42 paper and the use of short-light path (2.5 mm) cuvettes, filtration through a cytosieve (Gelman), or dilution will clear the specimen to give a reliable result. Several sources of error are possible: 1) wrong fluid (maternal urine, fetal ascitic fluid, multiple amniotic sacs, and amniotic cysts); 2) wrong pigment or pigment source (serum, hemoglobin, meconium and bilirubin associated with bilirubin regurgitation, as in fetal duodenal atresia); and 3) wrong dates (due to miscalculation of estimated date of confinement), either regarding the planning of the dates for amniocentesis or relating the results from a given amniocentesis to that expected. Minor blood-staining is not important.

The realization that one is determining differences in optical density and *not* absolute values of the "bilirubinoid" pigment is important. Thus, whereas the normal plot of absorbance (OD) of amniotic fluid at various wave lengths is virtually a straight line from 400-600 mμ, when hemolytic disease of the newborn is present, there is a consistent deviation at 450 mμ, and this *deviation* from the straight line is what is actually being measured (Fig 2). The OD may be read at intervals from about 600 down to about 350 mμ and the curve plotted, recording the peak difference at 450 mμ (or, in modern parlance, 450 nm, which is 450 x 10^{-9}M or 450 nanometers). Freda[5] noted ". . . In every abnormal tracing . . . deviation from the normal slope of the curve *always* begins at about 525 mμ, and the tracing *never* resumes the normal slope until about 375 mμ."

Three major levels of absorbance differences and their interpretations are as follows[3]: Group A, showing little or no deviation at 450 mμ and associated with little or no perinatal mortality and constituting about 25% of cases; Group B, showing a mild bulge of 0.08 to 0.15, constituting about 40% of cases and associated with need for therapy (transfusions or delivery before term or both); and Group C, showing a marked deviation (over 0.15), constituting about 30% of cases, and associated with a high incidence of perinatal mortality, even if everything possible is done.

The importance of amniocentesis is emphasized by Friesen and Bowman[6] in a neat summary of the five major advances in reducing fetal losses due to Rh sensitization: 1) the discovery of the Rh factor, in 1940; 2) the development of exchange transfusion, in 1945; 3) the selective induction of labor, in 1950; 4) spectrophotometric examination of the amniotic fluid, as reported by Liley,[7] in 1961; 5) fetal or intrauterine transfusions, first reported by Liley,[8] in 1963. According to Friesen and Bowman's report, the death rate in sensitized pregnancies has been about halved with each of these advances. Pathologically, though, amniocentesis is the latest advance, and its use will increase with recognition of its importance and adequate instrumentation of the clinical laboratories to perform the procedure.



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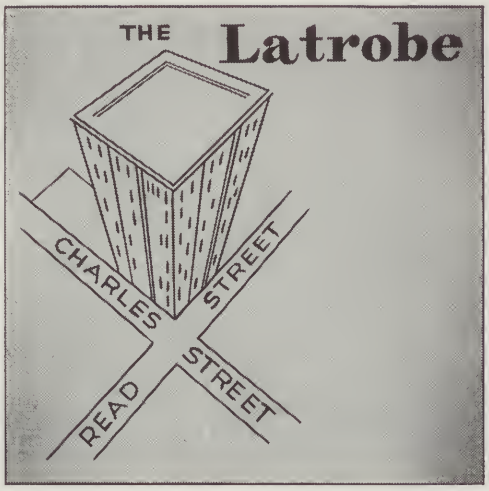
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Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
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EDITOR'S NOTE: This announcement from the Baltimore City Department of Education has special significance to all of us who work with children. Teenage reproduction is more frequently inefficient and is associated not only with more maternal complications but also with a high risk of low birth weight and all attendant handicapping conditions. The social support offered by this special school may go far to prevent repeaters and an excess production of handicapped future citizens.

An adolescent girl who becomes pregnant is a girl in trouble and one who needs help. She lacks a sense of values and has a poor self concept. Lack of success in school can be a facet of this image. As a girl learns to see herself as having some worth, and if she can see that she is making progress academically, it will be easier to help her make life readjustments.

This month, the Baltimore City Department of Education is opening a school for pregnant girls. The Edgar Allan Poe School #1, located at the northeast corner of Fayette and Greene Streets, will allow a girl to continue her education while pregnant so that she will not lose time and will be able to return to a regular school after her baby is born.

It is recognized that a school is only one of three approaches to the many complex problems facing a pregnant girl. In addition to continuing her education, each girl is expected to receive from a medical facility the proper prenatal care and help from a casework agency, not only for herself but also for her parents, the boy, and his parents.

The school will cover the secondary level, including grades seven through twelve, and if necessary will make individual provisions for an elementary school girl. The teachers will work with the girls with patience and understanding and will have the ability to individualize instruction. The school will operate on a 12-month basis.

All pregnant girls under 16 will be expected to attend the school. Girls will be transferred to School #1 from a regular school upon verification of pregnancy. It is hoped that agencies and doctors will also make referrals to the school.

Persons wishing to make referrals or having questions concerning the school should contact the principal, Mrs. Vivian E. Washington, 467-4000, ext 884.

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BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

PHYSIOLOGY OF EXERCISE

"The vast field of observation from which medical rehabilitation will have to synthesize its concepts and methods is the clinical physiology of exercise."[1]

Although the cardiovascular, pulmonary, renal, and hemopoetic systems play a supporting role during exercise, it is primarily the neuromusculoskeletal system which is active. This system acts as a unit. The basic physiologic unit is the reflex, and the basic anatomic unit is the peripheral nerve, the myoneural junction, and the muscle fiber.

1. Mechanism of Muscular Contraction.—The contractile molecule is a protein, myosin, of an approximate molecular weight of 800,000. In the rest phase, it is linked to a fibrous protein, actin. The myosin molecule can shorten by approximately 40% during contraction. Contraction is a chemicomechanical process in which the terminal high energy phosphate bond of adenosinetriphosphate (ATP) is split off, supplying energy for the mechanical changes in the contractile protein. Exact concentrations of calcium, magnesium, and potassium are important in this reaction.

Prior to muscular contraction the muscle cells are loaded and ready to contract when triggered by a depolarizing effect of sufficient magnitude; a wave of depolarization takes place, presumably disturbing the ionic equilibrium sufficiently to cause contraction.

Each motor nerve fiber or motor unit divides locally to innervate five to several hundred muscle cells. There is an all or none response of each motor unit. An artificial single stimulus to a motor unit or a larger segment is a muscle twitch. For .001 second after the stimulus reaches the muscle, there is a latent period without contractures, followed by an extremely short period of contracture. The refractory period is completed during the latent period (synaptic transmission and early depolarization). Repeated stimuli at 30 to 40 per second give a tetanus, a smooth wave of sustained contraction. Slower stimuli give a step like curve of contraction (incomplete tetanus).

Normally stimuli arrive through motor nerves at a rate of 10 to 15 per second. These stimuli act in an asynchronous manner on different motor units thus making a smooth motion.

2. Neurological Integration of Muscular Activity.—The activity of the neuromusculoskeletal system may be thought of as resting on reflexes of increasing complexity as activities become conscious and voluntary. Every unconscious or voluntary activity starts with a sensory component carried through a single synapse or group of synapses, resulting in motor nerve impulses and muscular activity. At the simplest level, the sensory stimulus of a tap on the quadriceps tendon is carried to the cord through a single synapse to the motor cells which are activated to cause sudden contracture of the quadriceps muscle. More complex reflexes are represented by the crossed extensor reflex and the tonic neck reflexes. A multitude of these involuntary reflexes subserve the more conscious activities, yet many conscious movements (such as walking) which require a prolonged learning process become practically unconscious. Even the most unusual and complex voluntary motions may be thought of as the result of the sensory reflexes entering the body through

sight, hearing, taste, and feeling. These sensory stimuli may be modified by complex higher centers concerned with judgment and memory, but in the sense that most experience is accumulated through the senses, we can think of motor activity as influenced by some recent or former sensory stimuli.

3. Functions of Various Levels of the Nervous System.—The spinal cord has three main functions: it contains the centers for the transfer of impulses; it contains the motor cells of the final common pathway; and it contains the basic elements of crude motor patterns, especially those of locomotion.

The subcortical centers are concerned with the smoothing of muscular activity and the integration of sensory stimuli from special sense organs and the labyrinthine apparatus.

The cerebellum also plays a smoothing and coordination role in movement, especially the integration of proprioceptive information into the motion pattern.

The cerebrum has been considered as the center of initiation of voluntary motion. We have mentioned above that much so called voluntary motion is set off from sensory stimuli and is only modified by judgment and memory in the cerebral centers. To some degree the cerebrum is a synaptic center between sensory information and muscular activity.

4. Nervous System Integration of Motion Patterns.—We can think of any individual motion starting as a response to some external event. Sensory data is fed into the cortical area through the special senses, where it is modified in the light of purpose and past experience. A choice is then made of a possible motor response which is started into execution through the efferent nerves. If the selected activity is one which has been learned, the activity will be performed semi-automatically. If it is a complex unusual motion, proprioceptive and sensory information from the cerebrum, the lower centers and the cerebellum will have to be integrated into the motion while it is being performed. The motor cells of the spinal cord are finally impinged upon as the final common pathway, and the primary reflexes are integrated into the activity.

5. Therapeutic Exercise.—Muscular function may be affected by a variety of neurologic diseases. Muscular activity may also be impaired because of faulty or painful joint function as well as by diseases which involve the muscle itself. In treating any disease which may affect mobility, the purposes of treatment will be of two types: 1) to develop voluntary, well-coordinated movements, 2) to develop strength and endurance. These two purposes are interdependent and must be developed to subserve the patient's needs effectively and safely.

6. Determination of Patient's Needs for Exercises.—To determine what type of exercise and how much is necessary, several factors must be taken into consideration. First, the diagnosis of the disease must have been established and medical treatment of the condition must have been started. The motivation and psychiatric background of the patient being treated must be understood. Second, a knowledge of the actual weakness or dyskinesia present must be obtained. A muscle test may be basic to an understanding of the location of muscular weakness. The effectiveness of treatment can be judged only by having an accurate initial evaluation of muscle strength. A third area which may be important is the sensory evaluation, particularly when dyskinesia is present. A fourth area of importance is the range of motion of joints, the presence of contractures and fibrosis of muscle segments. In muscle paralysis it is particularly important to consider the overall effect of isolated muscular weakness on long-term development of skeletal abnormalities. Finally, a goal must be set for each patient after consideration of the physical, emotional, social, financial, and vocational resources and deficiencies. Only then can a logical program of exercise be set up.

7. Techniques of Developing Muscle Coordination and Strength.—*A. Muscle reeducation:* When a muscle has suffered a complete or partial loss of its motor or sensory innervation, the patient may forget how to use the muscle effectively while the nerve is regenerating. This phenomenon is seen most strikingly in acute anterior poliomyelitis and in peripheral nerve injuries. Frequently, muscles which are not involved take over the activities of paralyzed muscles. The result is that the strong muscles hypertrophy, and the weak muscles are not used and therefore atrophy. It is important, therefore, to prevent substitution pat-

terns and to concentrate on bringing individual weak muscles to full strength while regeneration of the nerve occurs. During the period of regeneration, individual muscles are being strengthened and the use of the strong muscles is kept to a minimum.

B. Development of muscle strength: The strengthening of muscles which are weak because of partial denervation is based on the principal of graded gradually increasing load. With muscle strength grades of "trace" to "poor," the muscles must be strengthened individually by manual methods given by a skilled physiotherapist. It is unlikely that normal muscle can be injured by excessive exercise, but in poliomyelitis particularly, overwork of the muscle may result in declining strength. This may be detected by repeated muscle testing.

For strengthening normal muscle which has undergone disuse atrophy if there is no joint disease, heavy resistance with weights is the method of choice. The most effective method of developing muscle strength over a short period of time is called progressive resistive exercise (PRE). By trial and error, the maximum weight which the muscle can carry through full range of motion 10 times in a prescribed time period is found. This weight then is lifted through the full range of motion 10 times several times daily. This is carried out for five days each week, and the weight is increased each week to the maximum that the patient can do in the 10 motions.

C. Coordination: Coordination is the ability to perform a motion with the right timing of each muscle movement and the proper intensity of muscular contraction. Although coordination depends on normal functioning of all muscles and nerves in the area in use, a good deal can be done to prevent grossly incoordinated movements. This may be done by the prevention of substitution patterns and the use of braces and supports where permanent weakness may be present.

D. Endurance: Endurance refers to the ability to carry out repetitive movements for prolonged periods. Exercises designed to increase endurance do not require great effort but require prolonged repetition.

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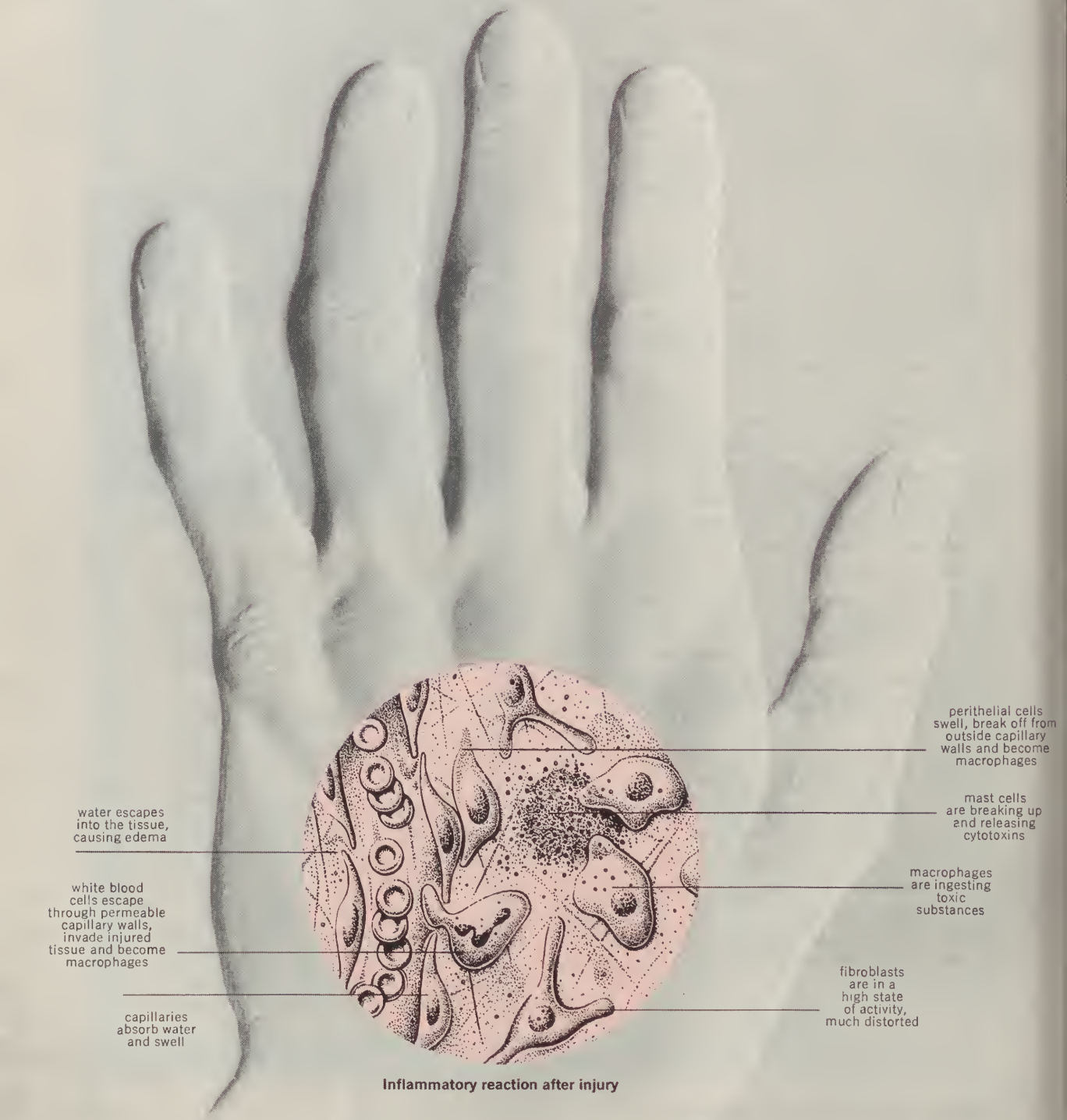
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IQ, Specific Abilities, and Adaptive Behavior

ALFRED M. POMMER, PhD
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The determination of IQ or mental age is a psychological measure; no reputable psychologist will contend that retarded children can be classified in terms of IQ or mental age alone. The president of the American Association on Mental Deficiency, in his presidential address of June 11, 1965, predicted that within 25 years the terms "mental age" and "IQ" will be used only when speaking or writing historically. D. O. Hebb, in his book, *The Organization of Behavior,* has demonstrated that the IQ which amounts to measurement of an average level of performance in a miscellany of tasks is inappropriate for persons with brain damage. Essentially, IQ tests should not be used to classify children because the performance in all types of intellectual effort must be known and because the computation of an average necessary for IQ tests wipes out information concerning the strength and weaknesses of the individual child.

Batteries of tests are being developed at The Johns Hopkins University, under the leadership of Dr. Henry Mark, which make possible the determination of a profile based on the intellectual ability most developed in a given child in relation to the other abilities of the child. A classification based on a profile such as this is clearly preferable for administrative and educational decisions than one based on either an IQ or a label of "trainable" or "educable."

In the classification of the mentally retarded, adaptive behavior may be more important than intellectual performance; an adaptive behavior rating scale has been developed and may be superior to our present classification of "dependent," "trainable," and "educable." It is certainly more meaningful than IQ. Consider the following example:

> We have two youngsters, both with an IQ, perhaps, of 50. One is able to remain properly dressed, uses limited but clean language, is not hostile, does not get into fights, and is generally not considered a community problem; and the other youngster is slovenly in his behavior, uses improper language, throws rocks, kicks dogs, goes around with his fly open (and here a girl has an advantage over a boy because a dress will stay down naturally). There should be little question in any of your minds as to which of your children will have to eventually be institutionalized or be brought to a clinic. . . . Both youngsters are considered to have the same intelligence, but one more clearly has a lower level of adaptation.[1]

Leland's "Proposed Definitions of General Adaptive Behavior Levels" are published in Parsons State Hospital and Training Center Project News 1, No. 9, December, 1965.

The Research Committee of the Maryland Association for Retarded Children has recommended that suitable steps be taken to improve the classification of retarded children by use of more appropriate and realistic criteria than those based on IQ or mental age. The Board of Directors adopted the recommendation and voted to form a special committee to study a substitute for IQ scores.

Although replacing IQ's is clearly in the best interest of the children involved, a suitable substitute must be acceptable to all professional groups concerned. The Maryland Association for Retarded Children, Inc. welcomes comments and suggestions from interested physicians. Communications should be sent to the Executive Director, Maryland Association for Retarded Children, Inc. 1514 Reisterstown Road, Pikesville, Md 21208.

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1. Leland, H.: Adaptive behavior as related to the treatment of the mentally retarded. *J Music Ther* 1:129-131, 1964.

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History and Objectives of the AAGP

G. OVERTON HIMMELWRIGHT, MD
President, Maryland Academy of General Practice

It is with great pleasure that the Maryland Chapter of the American Academy of General Practice is once again able to resume its contact with all physicians in Maryland through this *Journal.* Since the recent graduates of medical schools have not been exposed to the family physician or a general practitioner, due to the fact that medical school hospitals and their staff have been restricted to a practice of a referred, consultative, medically esoteric type, the modern young physician does not have the knowledge or understanding of the everyday medical practitioner, especially the family physician. The average young graduate in his medical discipline has not run the full gamut in his training of preventive and restorative functions in medical care, to the complete spectrum of deviations from health and actual medical practice, which involves first contact, continuing and comprehensive care of the individual, his family unit, as well as the role that society plays.

The first and general principle of the Academy is that the family doctor should be willing to accept total and continuing responsibility for the medical care of the patient as an individual, the family as a unit, and with society as a whole. The following is quoted from *AAGP History and Objectives.*

In the beginning, all doctors were general practitioners. Their job was to cure the sick. The same doctor treated mumps, malaria or gout.

Formal medical education simply didn't exist. Anyone interested in medicine, practiced medicine. There were no rules or regulations—just the Hippocratic oath. Success was on a trial and error basis. Gradually, of course, medical schools opened and offered formal teaching programs. But there were no standards of quality and the student didn't learn much more than he might have learned by sitting in a doctor's office.

Late in the nineteenth century, laboratories and centers of research announced new discoveries. Age-old mysteries were solved. Each new fact or bit of information unlocked other doors. The empirical approach was abandoned—the scientific approach had arrived.

It suddenly became impossible for one man to know all there was to know about medicine. Despite years of formal education, he could only learn so much. Medical care had reached an era of specialization.

This was good for medicine. It provided doctors who knew a great deal about certain diseases or parts of the body. These men were, and are, of invaluable assistance to physicians who treat the patient as a sick person.

There was, however, a secondary effect. The specialists set up examining boards to decide who could be a specialist. This, in turn, created an aura of glamour in the minds of medical students. Many became convinced that they could not be successful, either professionally or financially, unless they specialized. In 1940, only one out of every 10 medical students planned to enter general practice.

Soon the specialists outnumbered family doctors on many hospital staffs. The general practitioner found that he was not allowed to engage in many medical and surgical procedures—despite more-than-adequate training.

Today's general practitioner, or family doctor, doesn't *want* to do delicate surgery or handle complicated medical problems. When he needs advice or assistance, he calls in a specialist. However, he knows that he is qualified to handle more than 85 per cent of all illness.

The trend toward specialization hurt the family doctor. People began to regard him as a bearded old gentleman with a kindly countenance and frayed cuffs. He was a doctor who supposedly relied on herbs, tonics, Hinkle pills—and Fate. People lost confidence in him.

As late as 1947, at a New York Academy of Medicine meeting, the general practitioner was described as a doctor who couldn't get (or couldn't afford) specialty training.

More important, the pendulum's rapid swing led to misconceptions and confusion. People forgot that choosing the proper specialist is part of the family doctor's job and that self-diagnosis may be costly and dangerous.

The same people also forgot that a highly-trained specialist is not always able to perform the services of a competent general practitioner. It was soon acknowledged that years of concentration on a single specialty lead to the loss of basic knowledge. A routine physical

examination, by the family doctor's standards, would not be routine to the man who hasn't done one for many years.

By 1947, family doctors were in short supply. For years, medical schools had turned out too many doctors who planned to be specialists. Surgeons were available, as were obstetricians, pediatricians, gynecologists, ophthalmologists, cardiologists, and others. But the patient who woke up in the middle of the night with severe stomach cramps had forgotten who to call. He needed, and will always need, a competent family doctor.

To counteract the pendulum's swing, the American Academy of General Practice was organized in June, 1947. A handful of family doctors, no more than 150, met in Atlantic City. It was a spontaneous movement. First, they drew up a Constitution and set positive objectives.

1. To promote and maintain the highest standards of general practice.
2. To encourage medical students to became qualified family doctors.
3. To preserve the general practitioner's right to practice medicine to the full extent of his ability and training.
4. To provide postgraduate training opportunities for the family doctor.
5. To advance the science of medicine and the nation's health and welfare, and to preserve the right of free choice of physician to the patient.

The founders of the Academy were determined that this would be more than just another medical association. Its standards would be high; its program, objective.

A chain reaction started. State and county chapters were organized in all parts of the country. Today, the Academy has more than 28,000 members and is the nation's second largest medical association.

How were the objectives accomplished? What accounts for the Academy's growth? There are many answers.

First, the Academy set rigid qualifications for membership. It recognized that no doctor ever *completes* his medical education. If he is to keep up with progress, he must *keep* studying. This involves a loss of time and a sacrifice of income—but it's more important than either.

Consequently, the Academy became the first medical association to require *continuing* postgraduate education. Every three years, each member must complete 150 hours of accredited study. If he doesn't, he loses his membership. He can be reinstated only by making up lost hours.

The Academy is still the only medical association requiring postgraduate study. Although many specialist organizations have devised membership examinations, these are simply evidence that on a certain day, a certain doctor passed a certain examination. There has been no guarantee that these physicians keep abreast of current trends or take an active part in postgraduate education.

Actually, many Academy members could qualify for specialty rating. They prefer, however, to be general practitioners. They recognize the greater challenge and the greater opportunities for service in treating people —not merely diseases. They cherish the warm human relationships that can develop only between a family doctor and families under his care. They have learned the importance of approaching the patient as a complete individual, influenced by his family and community backgrounds, and subject to many pathologic and traumatic factors. They constantly seek training that qualifies them to evaluate the background influences as well as to treat the disease.

The purpose of the Academy's postgraduate program is to help members become better family doctors. The Academy does not wish to transform the general practitioner into a sort of hybrid or pseudo-specialist.

The annual scientific assemblies of the Academy, as well as the chapter's scientific assemblies, are designed to support postgraduate requirements. Unlike other medical meetings, each assembly program is part of a long range teaching plan. We in the Maryland chapter have an active educational committee, which is responsible for the long range program of postgraduate education here in our state and which works closely with the chairman of postgraduate education at the University of Maryland School of Medicine.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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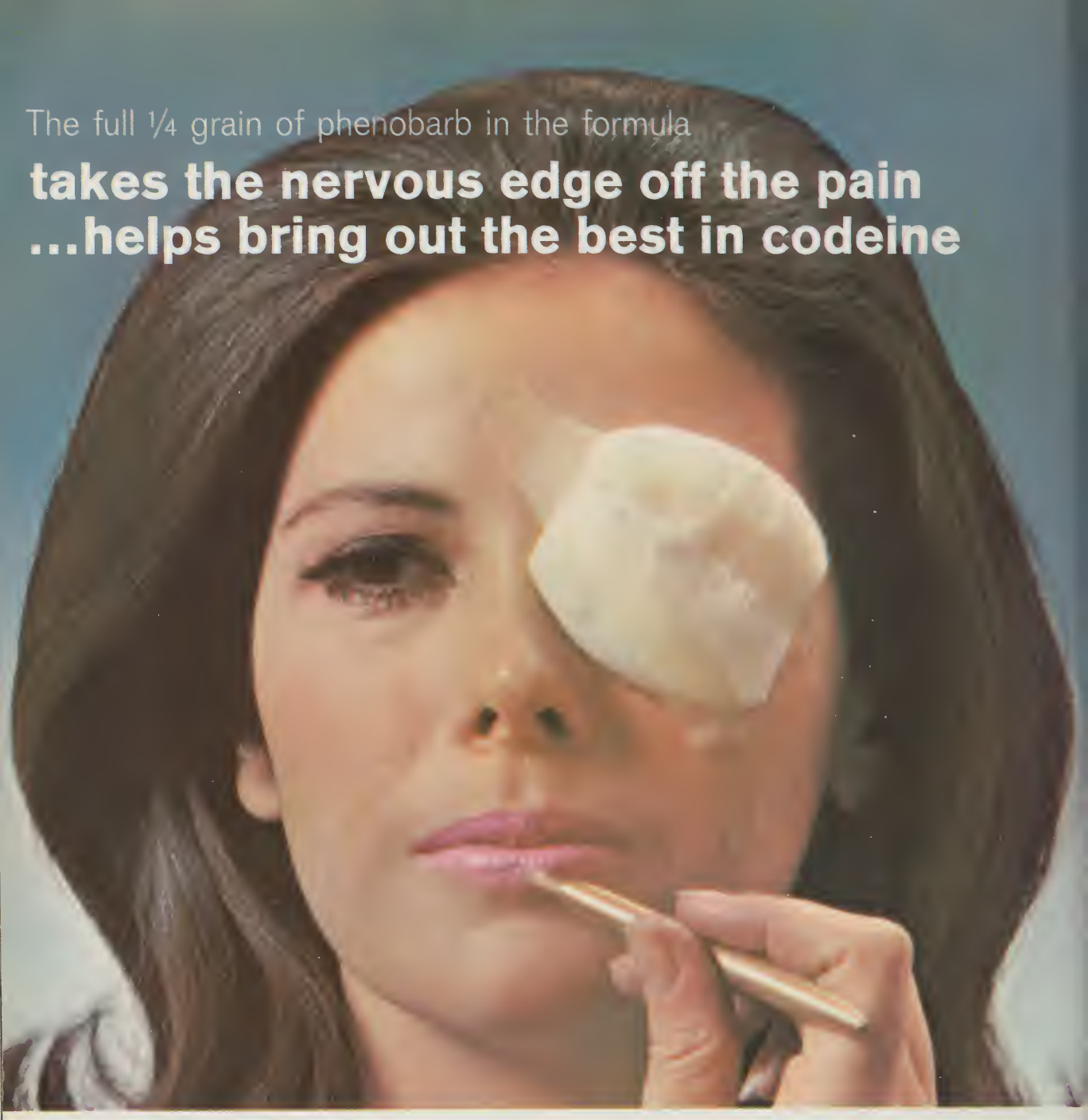
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

PROVES DIRECT LINK BETWEEN ALCOHOLISM AND ACCIDENTS

Seventy-three per cent of drivers responsible for fatal accidents, and 74% of fatally injured pedestrians had been drinking at the time, according to Dr. W. Haddon who spoke at a meeting on Accidents and Alcohol sponsored by the New York Medical Society on Alcoholism. Only 26% of similarly exposed drivers, and 23% of pedestrians who were not involved in accidents had been drinking.

These statistics for New York City correspond closely with statistics from Perth and Adelaide, Australia, Westchester County, Baltimore, Cleveland, Los Angeles County, Sweden, and elsewhere.

Using the results of laboratory and field experiments, and then concentrating on the epidemiology of accidents, Dr. Haddon examined both ends of the spectrum of drinking. He showed that levels of blood alcohol under 50 mgm% may be shown to lead to "over-representation in the accidents of the population and risk." There was also a direct correlation between the increase in blood alcohol concentration and the number of accidents.

In a study of 433 Toronto drivers in evening accidents compared with a control group obtained by stopping four or more drivers passing the scene in cars of the same vintage, Lucas et al had found concentrations in the 150 mgm% or over range, eight times as common in the accident group as in the non-accident involved group. This and other studies refute the widely quoted premise that intoxication is in some way accident preventive.

Tolerance to alcohol as found in alcoholics was no safeguard against accidents. In a Swedish study alcohol "misusers" (alcohol addicts, alcohol abusers, and execessive drinkers, as defined by Swedish law), each of whom would under certain situations fill the American definition of alcoholics, accounted for 70% of accidents where alcohol was involved. The heaviest users (and presumably the most tolerant) alone accounted for 48% of the alcohol-involved accidents despite their comprising only 3-5% of the population at risk.

Dr. Haddon concluded that epidemiological studies on traffic accidents would inevitably draw attention to alcoholism as a problem more basic than this particular one of its by-products. He further considered that the medical profession, which is the one profession that can deal with alcohol problems, should be closely involved in accident research and prevention.

Reprinted from *Physician's Alcohol Newsletter*, with permission of the New York City Medical Society on Alcoholism.



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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

Highlights

Immunization Project Grant

The Maryland State Department of Health has received a one-year grant of $158,922 from the Public Health Service under the Vaccination Assistance Act, to be used in the organization and administration of the Health Department's immunization project in Maryland counties.

This is an important step toward eradication of the common childhood diseases throughout the state: diphtheria, whooping cough, poliomyelitis, smallpox, tetanus, and measles. Primary objective is the immunization of all preschool children who have not already been vaccinated.

The first phase of the project will be an attack on measles. The Health Department plan has been endorsed by the Medical and Chirurgical Faculty of Maryland.

Dr. Whitridge Retires

John Whitridge, Jr., MD, who recently retired from the State Health Department, was employed as the department's first fulltime obstetrical consultant in 1945. He later became chief of the Division of Maternal and Child Health, and in 1956 was appointed chief of the Bureau of Preventive Medicine. Dr. Whitridge was instrumental in developing many programs to protect public health in the state and was largely responsible for the extensive growth of services in the bureau which he headed for the past 10 years.

Pamphlet on Department's Services

A pamphlet entitled "An Overview of Public Health Services in Maryland" has been published as part of an effort to help the public learn more about the activities of their health department. It was designed especially for use by school children, who are often required to study the functions of the department as part of such courses as health, social studies, and civics.

Montebello Accredited

Montebello State Hospital has been accredited by the Joint Commission on Accreditation of Hospitals for a period of three years, or until a subsequent survey is conducted.

Physical and Occupational Therapy Courses

The Divisions of Physical and Occupational Therapy presented a four-day course, "The Consultative Process," for occupational and physical therapists. The purpose of the course, developed by Cornell University under a short term training grant from HEW, is to improve the quality of consultative services being rendered by therapists working with staffs of hospitals, nursing homes, and community agencies.

With the increased numbers of chronically ill and disabled persons and the potential of rehabilitating these people, there has resulted a growing demand for therapists to serve in the consultant capacity within their respective facilities. Hopefully, the course will enable therapists to greatly increase the scope of their services and to extend them to a greater number of patients.

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Participants represented a broad range of facilities and health agencies throughout the state.

Communicable Disease Training Course

As a result of the increased incidence of Rocky Mountain spotted fever and in anticipation of possible mosquito-borne encephalitis cases during the coming months, the Division of Communicable Diseases organized a one-day rapid training course in the techniques for investigating these two insect-borne diseases. The course was conducted in Baltimore as a service of the Public Health Service's Communicable Disease Center without cost to the department. It consisted of short lectures on the principles of disease investigation, serology, statistical procedures, field methods, and measurement of animal population.

Laboratory Diagnosis of Tuberculosis

The culturing of sputum and other body fluids continues to be important in the diagnosis and management of tuberculosis, and analysis is growing more complex. Of the 20,000 specimens a year examined in the department's laboratories, 3.6 to 4% are positive for tubercle bacilli. In addition, 1 to 2% are positive for organisms resembling the tubercle bacillus. These atypical organisms may belong to various groups. Increased knowledge of the diseases they may cause has required more exacting procedures for identification.

Cultures positive for tubercle bacilli are tested for the susceptibility of the organism to the three drugs most commonly effective in treatment. The Baltimore City laboratory is making a study to determine susceptibility of the organisms to some of the experimental or secondary drugs.

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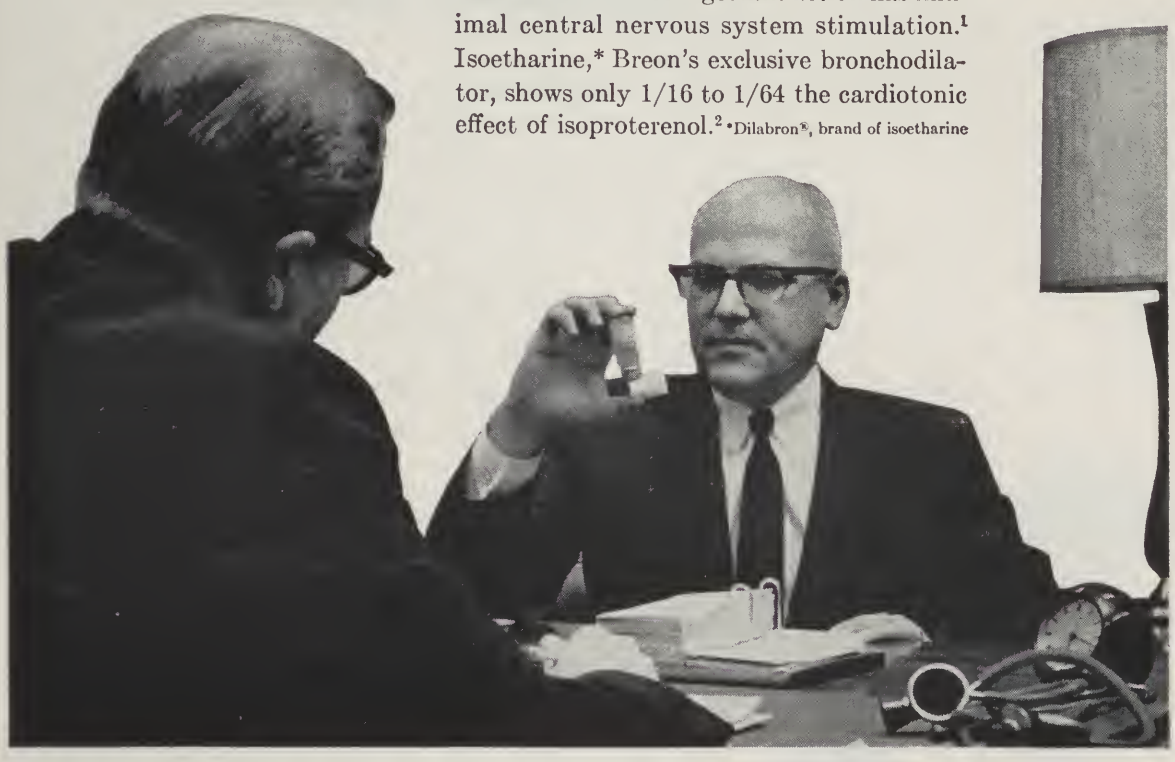


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RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

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References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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Learn To Do Your Part In The Prevention Of Disease

Midyear Analysis

The following midyear analysis of Baltimore's health was prepared by Dr. Matthew Tayback, deputy commissioner of health for Baltimore City.

Diseases for which a specific preventive agent exists, namely, diphtheria, tetanus, and whooping cough, are firmly under control. Results of continuing surveys by the department's Bureau of Biostatistics indicate that the immunization status of children against these diseases and against poliomyelitis is at a high level.

Measles occurred in epidemic proportions in the inner city during the first half of the year. There is absolutely no need for a recurrence of such an outbreak. Every preschool child between 1 and 6 years old who has not had measles should be vaccinated, if he has not already been. Physicians may refer medically indigent children to City Health Department inoculation clinics.

Tuberculosis, a chronic communicable disease, continues to defy every effort to reduce its incidence. During the first half of 1966, the number of new active cases was 354, no significant change from the same period last year. Although such a comparison appears to suggest no improvement at all, we have additional information to indicate that progress is being made in preventing transmission of the infection to children. This is a first and necessary step in making a fundamental impact upon the future of the disease in this city.

Among the causes of death, we note that the first half of 1966 produced a 27% rise in deaths from pneumonia and influenza as contrasted with 1965. This was due to a substantially higher level of acute respiratory disease in the first three months of the year than we customarily experience. In this respect, developments leading to increasingly more effective influenza vaccines should help reduce the number of severe episodes of this disease.

It is unfortunate that this year, to date, we are experiencing an increase in each of the causes of accidental death and in deaths from homicide and suicide. Of particular concern is the 100% rise in deaths due to homicide during the first six months of 1966, as contrasted with the like period for 1965. The ease with which people in the city can secure small arms is probably one of the reasons underlying this problem.

On the brighter side, we have further evidence of the success of the planned parenthood services, which have been substantially expanded in the past two years. The number of births for the first

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six months is down 5% from 1965. When one considers that births in 1965 dropped 10% from 1964, the total effect is remarkable. Analysis carried out by the Bureau of Biostatistics indicates that mothers in low socioeconomic circumstances are experiencing the full benefit of these new services.

The difference in mortality between white and nonwhite infants is a matter of concern. The basic issue is one of social and economic opportunity; however, we are attacking this problem by several new medical services, including our Maternity and Infant Services Project, with headquarters in the Baltimore Maternity Center, 211 W Lombard Street.

Medical Care Program

Physicians have been notified that beginning July 1, 1966, the Baltimore City Medical Care Program began operating under regulations governing all other sections of Maryland, in view of the fact that city and county programs have been unified to obtain funds under Title XIX of Public Law 89-97.

Patients may now go to any physician who will accept them and may seek help in any hospital of the city or county. Physicians will be paid on a set fee-for-service, whereas hospitals will receive their costs as certified by a hospital cost-accounting service. The Department of Public Welfare will certify the eligibility of all persons requesting medical care under this program and will issue all new medical care cards.

Physicians will receive copies of the regulations pertaining to this new program as they become available.

Requirements for Communicable Diseases

A new communicable disease chart delineating the requirements for communicable diseases is available from the Bureau of Communicable Diseases in the Baltimore City Health Department, telephone PLaza 2-2000, extension 314.

The chart, which is Regulation 2 for the control of communicable diseases, was adopted and amended effective April 1, 1966. It describes the various communicable diseases, gives the common early signs and symptoms, and lists the isolation requirements for patients and contacts.

Robert E. Farber, MD
Commissioner of Health



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Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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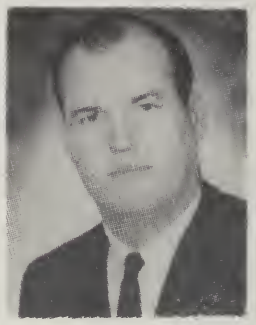
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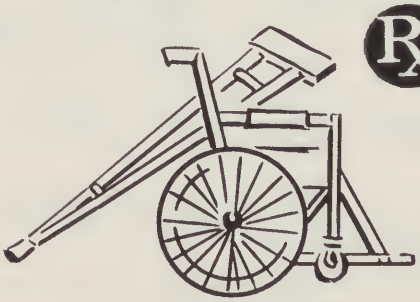
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STATE OF MARYLAND

Department of Mental Hygiene

Isadore Tuerk, MD, Commissioner

Kurt Gorwitz, Statistics Director

Fact Sheet for 1966 Fiscal Year

In 1966, for the seventh year in a row, Maryland's hospitals for the mentally ill treated a record number of patients, reflecting the continuing rise in admissions. Despite a gradual decrease in the number of long term patients and in the length of hospitalization of those newly admitted, the average size of the patient population increased for the second consecutive year. This is counter to the nationwide experience of a small but persistent annual decline. Data for Maryland are summarized in the Table.

FISCAL YEAR	AVERAGE SIZE OF PATIENT POPULATION	TOTAL NUMBER TREATED DURING YEAR	ADMISSIONS	TOTAL SEPARATIONS
1956	9,530	15,477	3,785	3,349
1958	9,147	16,197	4,015	4,412
1960	8,576	16,268	4,640	4,751
1962	8,291	17,580	6,221	6,111
1964	8,035	19,424	7,871	8,104
1965	8,102	21,542	9,675	9,735
Net Change	—1,428	+6,065	+5,890	+6,386
Percentage Change	—15.0	+39.2	+155.6	+190.7

The continuing rise in the number of mentally ill patients treated annually primarily reflects the rapid expansion in admissions. The 9,675 patients admitted during 1966 represented an increase of 1,124, or 13.1%, over the previous year's comparable figure; this in turn reflected an increase of 680, or 8.6%, over the 1964 figure.

A similar rise in admissions has been noted in most states. Because of this, the question is frequently posed whether this indicates a rising incidence of mental illness. This can not be readily answered since the numeric relationship between the number of hospitalized patients and the total number of mentally disturbed or ill cannot be determined. However, it is generally believed that the incidence rate of most mental illnesses has not changed appreciably and that these expanding figures therefore reflect mainly the growing acceptance and usage of mental hospitals as short term intensive treatment facilities for alcoholism and acute psychoneurotic and personality disturbances.

Substantial overcrowding continued also at Rosewood, Maryland's major hospital for the mentally retarded. It therefore persisted in its policy of relating the number of admissions to available space and staff. Despite this restrictive policy, the average number of retarded patients at Rosewood and Henryton increased 187 to 2,888.

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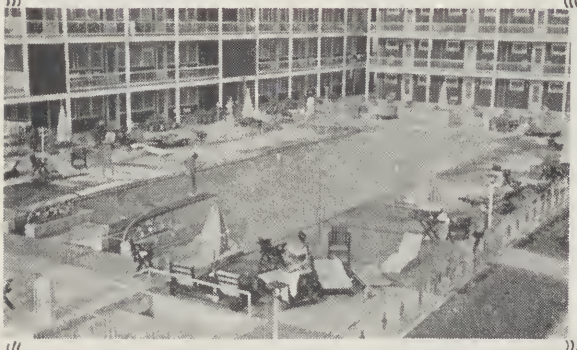
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Ten years ago, prior to the opening of Henryton, Rosewood had a patient population of 1,723. In an effort to reduce this chronic problem, the Department is engaged in a three-pronged program involving the construction of additional buildings at Rosewood, the establishment of new facilities in the Baltimore and Washington metropolitan areas, and the development, with the Health Department, of coordinated community based services as alternatives to hospitalization.

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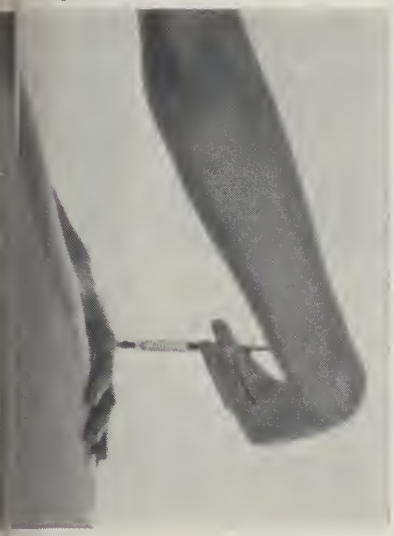
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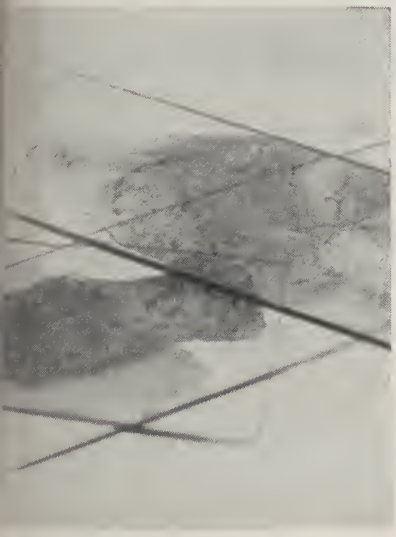
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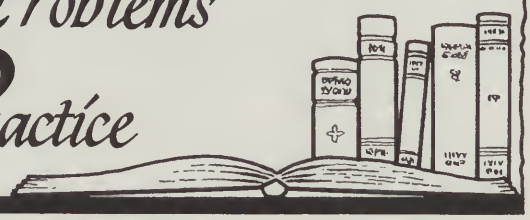
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Solutions to Business Problems in Daily Medical Practice



Collection Routine

Part I: Accounts Receivable Management

WILBURN L. McCLURE, JR.

When a patient opens the door to your office, the accounts receivable routine begins. It climaxes as the patient prepares to leave.

As distasteful as the task of maintaining financial records and collecting money may be, it is, nevertheless, a vital part of your responsibility to the patient.

Patients seldom will attack your ability as a physician, but with little hesitation many are eager to discredit your standing as a businessman.

Now is as good a time as any to sit down in the business office with your aide and evaluate these questions:

> Do I have comprehensive accounts receivable records?
>
> Do I make it easy for patients to understand their financial obligation to me?
>
> Is the collection approach working?
> Is the billing system adequate and efficient?

The following recommendations should constitute the vast part of the management of your accounts receivable routine. Extend and revise to suit your office, but try to include the following basic ideas.

Access to aides: An aide must be strategically located to greet each patient. Ideally, the aide should be able to interview each patient privately or, as the case may be, to review and update present information.

Accurate records: Each patient's financial record should reveal the following: the patient's full name (emphasis on correct spelling); who is to be billed, if other than the patient; complete billing address, including house number, apartment number (if any), street, city, state, and zip code; telephone number, including any extension numbers and area code; place of employment (if housewife or dependent, include such information on husband), including phone number and extension.

It is also important to include the insurance company's full name, address, phone number, policy number, and name of insured as it appears on the policy.

Fee discussions: The major step toward an understanding between doctor and patient, in the financial sense, begins with a frank discussion of fees necessary for services rendered. Since your fees are not overtly labeled, you cannot take for granted that a patient will accept or understand every fee charged. Have a fee schedule handy.

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*



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Most important, encourage your patients to discuss fees with you *rather than with your aide.*

Intra-office communications: Once you have discussed your fees with the patient, how do you relay the information to the aide? Before seeing a patient, how can you be advised about a delinquent account or one which is approaching the too high mark?

A charge or service slip generally fits the need. A well designed one has a place for the date, patient's name, and a list of services generally rendered, with extra lines for special cases. It also has a special area for previous balance due (if any), amount of today's services, subtotal, today's payments (if any), and the current balance.

The doctor enters his fees, and the slip is returned to the aide for completion. Complete details on one such system are available without charge from the author upon request.

Collection approach: Equally as important as greeting the patient is the availability of an aide as the patient prepares to leave the office. This way she has the opportunity of making the patient's next appointment and collecting your fees.

The aide must be able to quickly summarize the account and arrive at the current balance due. Then she needs but two remarks for her collection repertoire: "That will be_____dollars for today's visit," and, "Your current balance is_____ dollars." No alternatives. No options. Just facts.

Billing system: All account cards must be accurate and complete before each billing period. Ledger cards fully itemized are the most desirable. Always itemize charges for surgical procedures, lab fees, x-rays, electrocardiograms, injections, and drugs dispensed. Send your bills promptly at the same time each month. Delays will offer the patient an excuse that he "did not get it on time."

So far, accurate record keeping, fee discussions, collection and billing techniques have been discussed. What, then, should you do about delinquent accounts? Read next month's column, "Collection Routine, Part II, Using Intra-office Techniques."

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

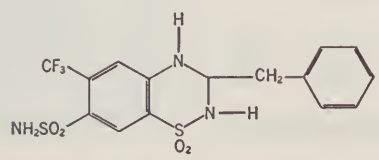
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.



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Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

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References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.

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INAUGURAL ADDRESS

MRS. ARCHIE R. COHEN
President, 1966-1967

Read at the annual meeting, Woman's Auxiliary to the Medical and Chirurgical Faculty, April 28, 1966.



In this springtime of the year, God does make all things new in the world of nature. So does our organization, the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, annually assign new names to title its leadership.

To the best of the past and mix it with the good of the new, your new officers will serve you the best of today, with hopes that for the tomorrow we will be able to do even better.

Working with Mrs. Strobel has been most gratifying this past year. Through her tireless enthusiasm and efforts, I have been filled with hope and confidence.

In accepting the responsibility of leadership, I have the staunch support and aid of, first, my husband, Archie, and then, hand in hand, with the past officers and all members from throughout the state and the Washington County girls and the new board, all of whom are devoted to Auxiliary work; and I feel assured of cooperation from every corner.

My aim will be first, to fulfill the objectives of the Auxiliary, whose principal purpose is to encourage and advance public understanding and education concerning matters of public health as approved by the Medical and Chirurgical Faculty.

Our motto, "Hygeia filiae," handmaidens to health, proclaims us to be helpers. We can develop greater understanding and interest in problems our husbands face when we work together for health education, research, future medical careers, and community service.

This year ahead will be one of challenge, one of change in medical practice, and we must prom-

ise to keep informed so we may be correctly tuned to the questions that come our way. Let us keep our answers a tribute to the medical profession.

Legislation, community service, mental health, all give us the impetus to reserve a moment daily for education. Listen, learn, and remember the important facts that are changing daily, throughout the neighborhood, the state, and the nation.

We shall try very hard to keep smiling, and keep promoting better health, through safety and through research. Let us take with us this short quote: "To whom much is given much is required." I will give my best, and together we will serve and accomplish.

Maryland Auxiliary Gets AMA-ERF Merit Award



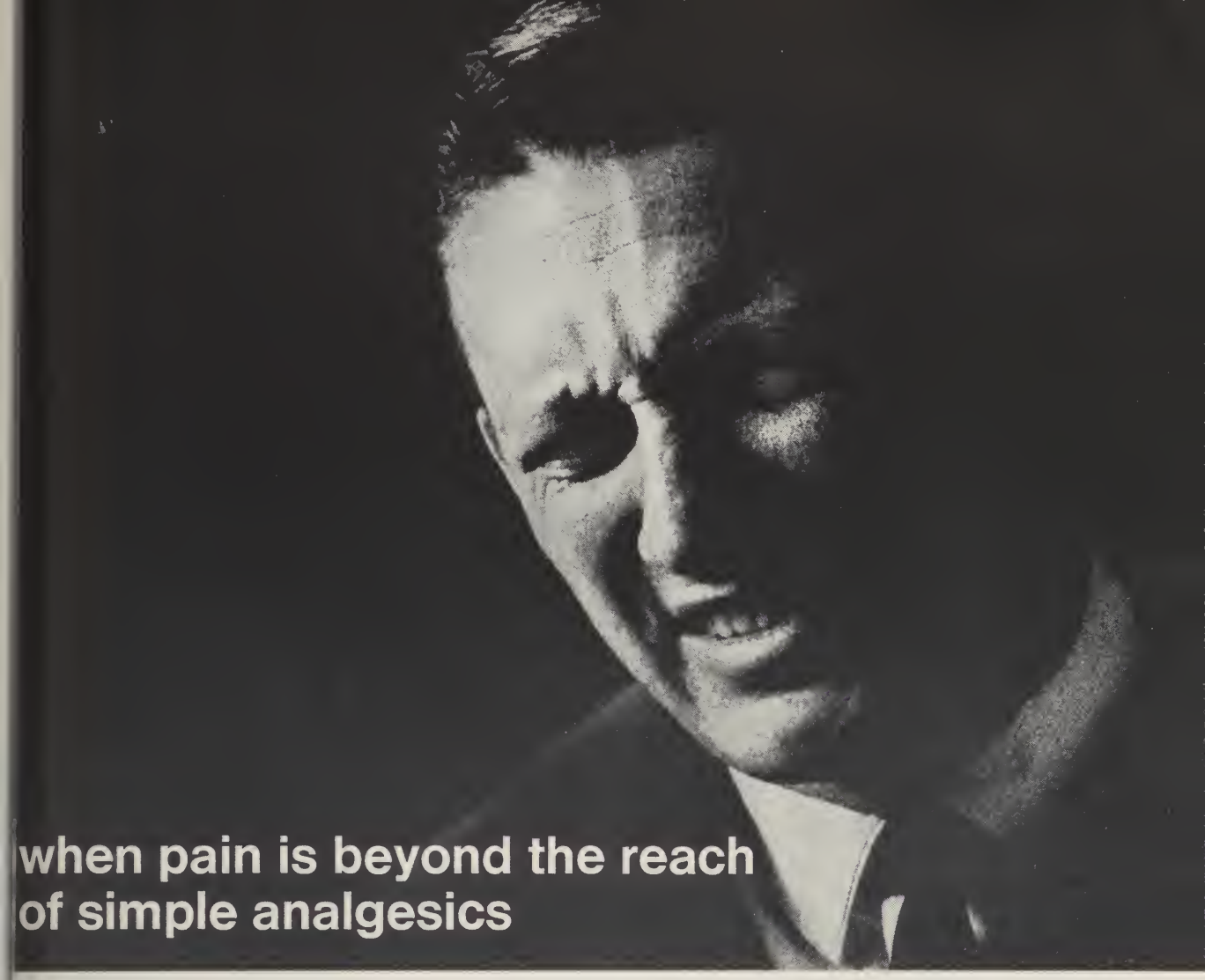
L-R: Mrs. John E. Baybutt, Mrs. Wallace H. Sadowsky, and Mrs. Archie R. Cohen.

The Woman's Auxiliary to the American Medical Association set another record in its annual contribution to the AMA Educational and Research Foundation—$345,573.81.

For its contribution of $5,892.72, the Maryland Auxiliary won an award of merit. Merit awards are presented to the auxiliary raising the largest amount in each of six membership categories.

Said Raymond L. McKeown, AMA-ERF president:

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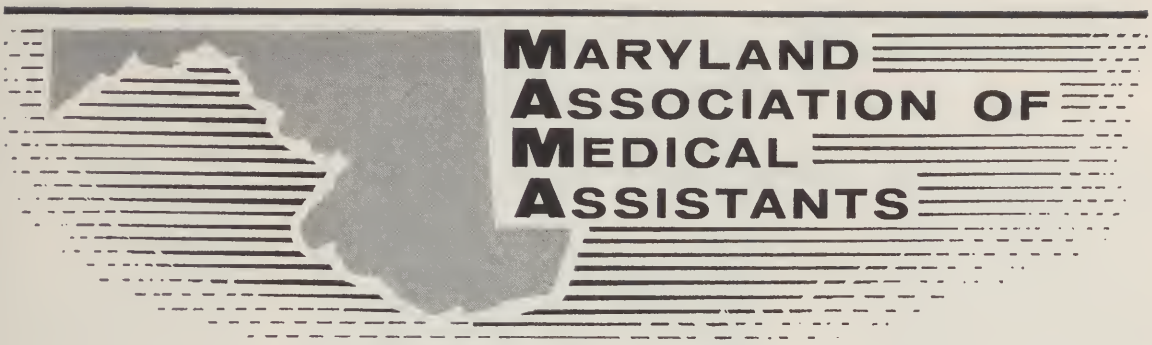
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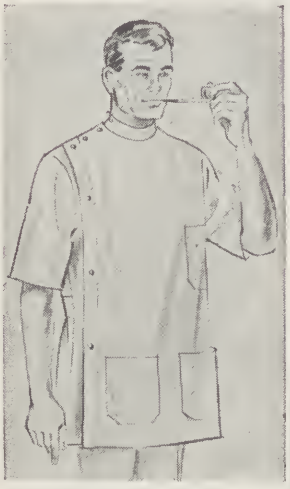
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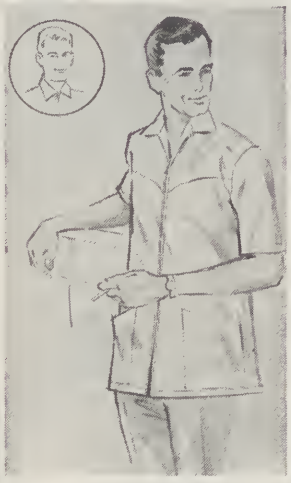
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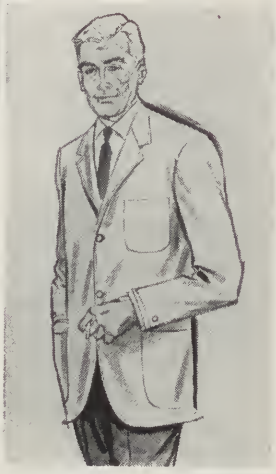
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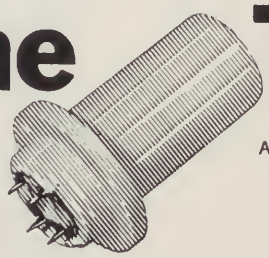
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Book Reviews

FERMENT IN MEDICINE, by Richard M. Magraw, MD. Saunders, 1966. $6.50

The changing needs and patterns of medical care and practice have furnished the basis for this book. Its purposes are twofold: 1) to analyze and define those elements in traditional forms of medical practice which are essential to optimal medical care and maintenance of health for everyone; 2) to describe and discuss some of the major forces now acting to modify existing concepts, practice, and institutions in medicine.

BLOOD DISEASES OF INFANCY AND CHILDHOOD, ed 2, by Carl H. Smith, MD, C. V. Mosby Co., 1966. $22

Recent advances in pediatric hematology are introduced in this edition. Selection of material has been based on that which would interest the practitioner and contribute toward diagnosis and treatment.

SPONTANEOUS REGRESSION OF CANCER, by Tilden C. Everson, MD, and Warren H. Cole, MD, W. B. Saunders Co., 1966.

With the thought that isolated "cures" of cancer from unorthodox therapeutic measures might actually be spontaneous regressions of cancer, the authors reviewed the world medical literature since 1900 for evidence both supporting and refuting their theory. Added to this accumulation of data were many personal communications relating unpublished cases of cancer in which there was evidence of biologic control, as well as information concerning spontaneous regression of benign tumors, prolonged arrest of cancer after no treatment or inadequate treatment, and delayed recurrence or delayed metastasis of cancer after treatment of the primary cancer.

This monograph reports the results of their study. Their findings for each of the various types of cancer are illustrated by cases which the authors considered to be possible examples of spontaneous regression of cancer.

BIOMECHANICS AND RELATED BIO-ENGINEERING TOPICS, edited by R. M. Kenedi, Pergamon Press, 1965. $20

This book contains a selection of papers presented at a symposium held in Glasgow. The purpose of the symposium was to promote correlation between the contributions made by different disciplines in relation to the various problems studied. Among the topics covered are developments in surgical and laboratory instrumentation, diagnostic applications of ultrasound, and telemetering techniques.

OPERABLE HEART DISEASE, by Howard D. Sirak, MD, C. P. Mosby Co., 1966. $12.50

This book is intended as a guide to understanding the basic problems in anatomy and physiology as applied to the diagnosis and treatment of heart disease. Directed toward students and specialists in training, it demonstrates the need for a sound background in circulatory and respiratory physiology in the interpretation of electrocardiograms and data from cardiac catheterization and in evaluating the circulatory dynamics, respiratory changes, and metabolic considerations of the postoperative period.

RESUSCITATION OF THE NEWBORN INFANT, ed 2, edited by Harold Abramson, MD, C. V. Mosby, 1966. $16.50

Since publication of the first edition of this work, interest has surged in neonatology and problems related to the dynamics of respiration and circulation of newborn infants. Many new solutions have been found, and these are incorporated in this new edition.

Rapid establishment of the respiratory mechanism is only the first step in resuscitation. Early diagnosis of the underlying cause and institution of therapy to assure continued survival are likewise necessary.

This edition, like its predecessor, has been prepared by the Special Committee on Infant Mortality of the County of New York.

THE PEDIATRICIAN'S OPHTHALMOLOGY, edited by Sumner D. Liebman, MD, and Sydney S. Gellis, MD, C. V. Mosby, 1966. $19.50

Through the collaboration of an ophthalmologist and a pediatrician, material most needed by the pediatrician has been selected and translated into terms understandable to the pediatrician and the general practitioner. It is designed to help these physicians recognize eye disorders of childhood, particularly in the young infant. The editors have attempted to make each chapter as complete as possible, anticipating that the reader would turn to a particular chapter for reference rather than reading the book from cover to cover.

OSTEOTOMY AT THE UPPER END OF THE FEMUR, by Henry Milch, MD; edited by Robert A. Milch, MD, Williams & Wilkins, 1965. $11.25

The choice between the various types of osteotomy should be made upon consideration of the change each accomplishes in the effective axis of the bone. In the author's opinion, too much concern over the details of technique has beclouded the wider significance of osteotomy as a "solution of continuity." Proper evaluation of the consequences of such solutions of continuity, whether induced surgically or accidentally, presuppose a concept of the action of the femoral neck and of the limits of motion possible at the hip joint. The author bases his monograph on 40 years of experience.

Dr. Henry Milch completed this monograph just a few hours before his death, on March 3, 1964. It was edited by his son and published as a tribute to the author and his works.



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PRINCIPLES OF ORAL SURGERY (Pergamon Series in Dentistry, Vol 3), by J. R. Moore, Pergamon Press, 1966. $7.25

This is an introduction to oral surgery for dental students. It describes the operations on the teeth and jaws normally performed by the dental surgeon.

SYMPOSIUM ON SURGERY OF THE OCULAR ADNEXA, by the New Orleans Academy of Ophthalmology, C. V. Mosby Co., 1966. $16

This is a compilation of the lectures presented before the New Orleans Academy of Ophthalmology in February, 1965. Among the distinguished participants is Howard Naquin, MD, of Baltimore. The participants have discussed the pathogenesis and diagnosis of each condition and have described the treatment they have found most satisfactory.

ADVANCES IN BIOLOGY OF SKIN, Vol VI, AGING, edited by William Montagna. Pergamon Press, 1965. $15

"It is conceivable that under ideal circumstances tissues might remain unchanged in time and that animals could live forever."

With these striking words the editor commences his preface to this volume. But, he then points out, serious problems of survival would result and the pattern of nature is that neither tissues nor animals are indestructible. Aging processes in general are gradual and cumulative and progressive deterioration of the skin is one of the most obvious indications of human age.

Knowledge of aging skin has not advanced rapidly even though there has been considerable study of the subject. This volume has, therefore, a significant and valuable purpose. Containing the papers presented at the 14th Symposium on the Biology of Skin, held at the University of Oregon Medical School, it combines varied disciplines which have been used in the study of aging phenomena and focuses attention upon the skin. The contents of the volume cover studies in morphology, biochemistry, and physiology.

SYNOPSIS OF OBSTETRICS, ed 7, by Charles E. McLennan, MD, C. V. Mosby Co., 1966. $6.85

This is a pocket-sized, precise synopsis of obstetrics designed primarily for the undergraduate medical student. It continues to emphasize basic principles. This revision presents some newer information and has eliminated a great deal of information no longer pertinent.

ARTERIOGRAPHY, PRINCIPLES AND TECHNIQUES, EMPHASIZING ITS APPLICATION IN COMMUNITY HOSPITAL PRACTICE, by Joseph L. Curry, MD, and Willard J. Howland, MD, W. B. Saunders, 1966. $14

This book offers a brief introduction to arteriography for the community radiologist and other physicians who wish to initiate such procedures in their own hospitals. The material is based on the experience of the authors in a community hospital and represents the gradual evolution of techniques and the recognition of various problems as they were encountered in more than 1,200 arteriographic procedures.

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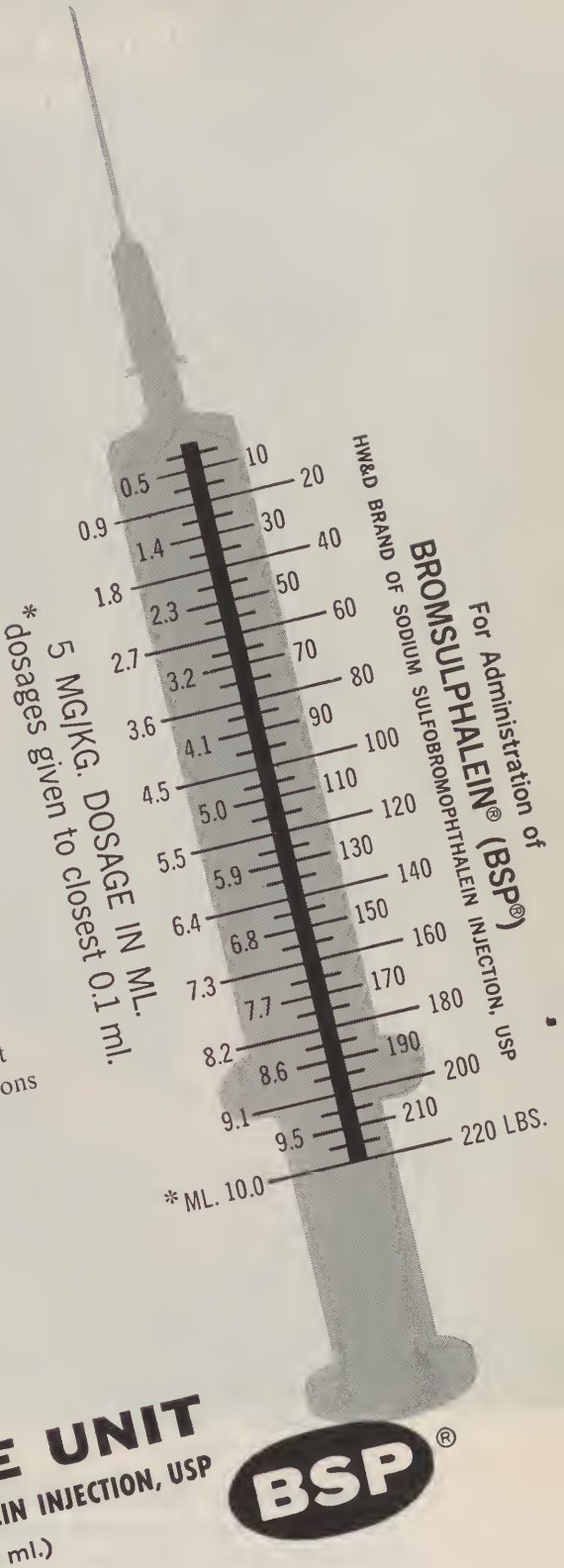
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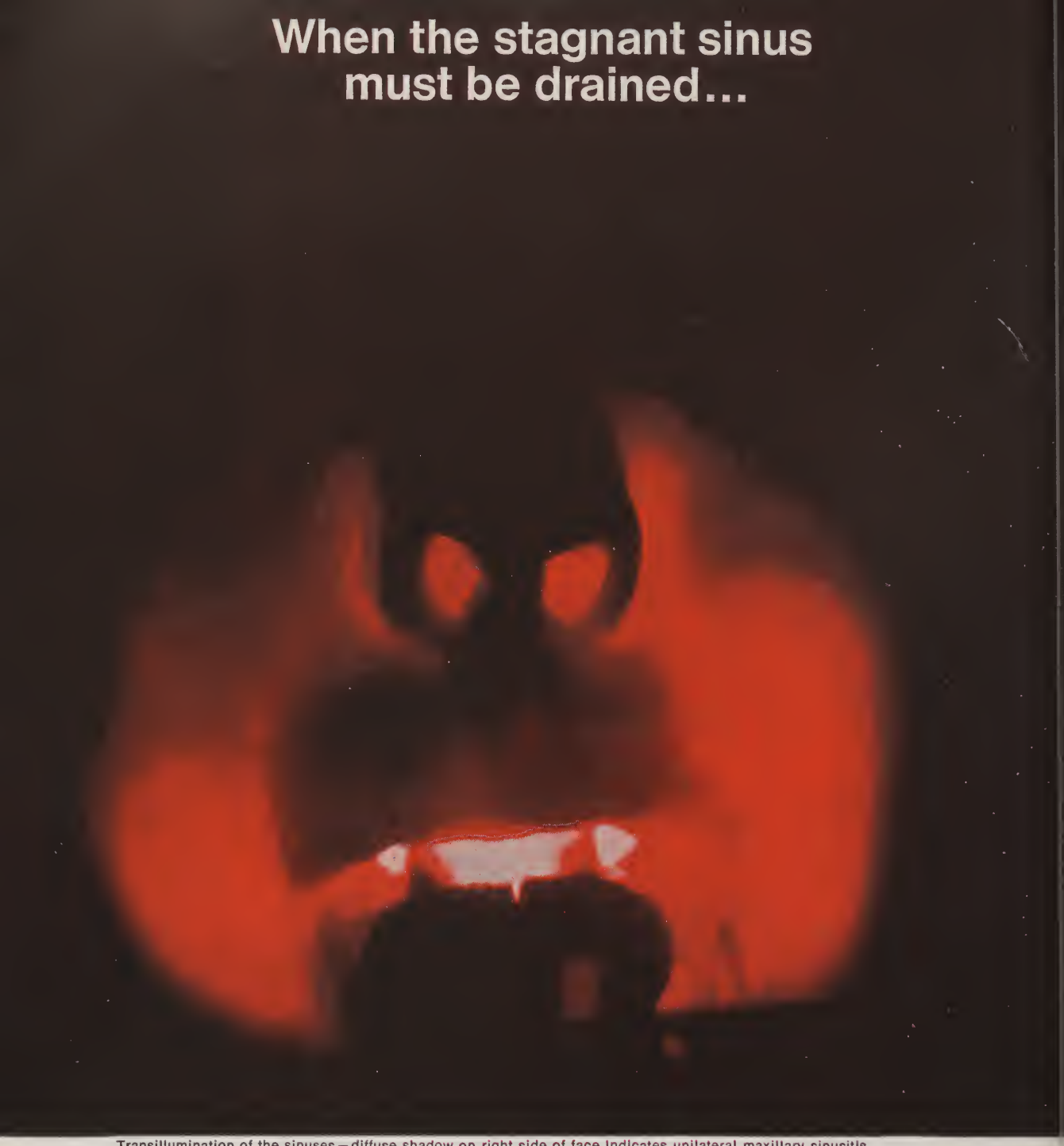
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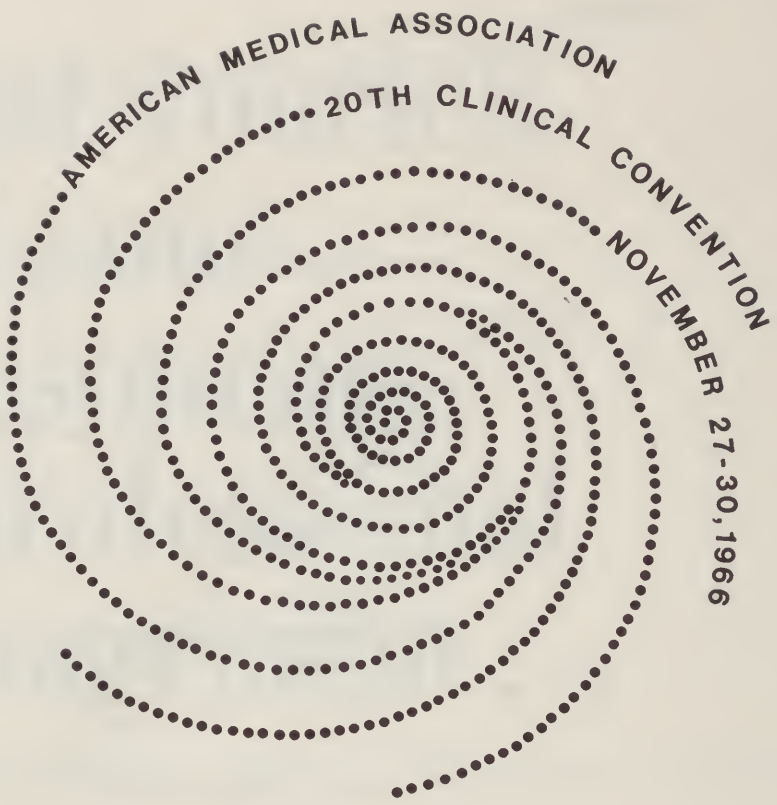
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The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA October 24.

Doctors take note...

MEDIC

FRIDAY POSTGRADUATE PROGRAMS

See page 151 for list of locations where MEDIC programs may be heard

OCTOBER 21, 12:30 PM
Selection of Patients for Cardiac Surgery

R Adams Cawley, MD, professor and head, Division of Thoracic Surgery, University of Maryland School of Medicine.

OCTOBER 28, 1:00 PM
Hypoglycemia

David Rabinawitz, MRCP, assistant professor of Medicine, The Johns Hopkins University School of Medicine.

NOVEMBER 4, 12:30 PM
Organic Versus Functional Psychoses: Differential Diagnosis

Virginia Huffer, MD, associate professor of Psychiatry, University of Maryland School of Medicine
and
Lindbergh S. Sata, MD, assistant professor of Psychiatry, University of Maryland School of Medicine.

NOVEMBER 11, 12:30 PM
Pediatric Surgical Emergencies

J. Alex Haller, Jr., MD, associate professor of Surgery, The Johns Hopkins University School of Medicine.

NOVEMBER 18, 12:30 PM
Practical Dermatologic Diagnosis

Thomas W. Cooper, MD, Hagerstown.

NOVEMBER 25, 1:00 PM
Intersex Problems

Milton S. Grossman, MD, assistant professor of Pediatrics, University of Maryland School of Medicine.

ALCOHOLISM FAIR

October 27-28, 3:30 PM-6:30 PM

Exhibits, movies and literature provided by 15 assorted agencies and groups to demonstrate to doctors and the general public what is being done in the community to help the alcoholic and his family.

Free admission
Refreshments

Question and answer period: 5:00-6:30 PM, each day.

Sponsored by the Baltimore Area Council on Alcoholism, Inc.

Church of the Redeemer Parish Hall, Baltimore

BALTIMORE CITY MEDICAL SOCIETY

November 4, 8:30 PM

"Endocrine Problems of the Adolescent"

Georgeanna Seegar Jones, MD, associate professor, Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

"Congenital Anomalies as a Cause of Primary Amenorrhea"

Howard W. Jones, Jr., MD, associate professor, Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

"The Adolescent Goes to a Gynecologist"

Allan C. Barnes, MD, director, Department of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine.

•

Question and Answer Period

•

Acceptable for two hours Category I Credit by the American Academy of General Practice

•

There will be a report of the Nominating Committee and nominations from the floor during the business meeting immediately following the scientific program.

1211 Cathedral Street, Baltimore

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

November 1, 7:30 PM

"Neuroleptanalgesia"

N. W. B. Craythorne, MD, professor and chairman, Department of Anesthesiology, West Virginia Medical Center, Morgantown, West Virginia.

1211 Cathedral Street, Baltimore

MARYLAND PSYCHIATRIC SOCIETY

November 10, 6:30 PM

DINNER MEETING

"Short Term Therapy"

Eugene Meyer, III, MD, professor of Psychiatry, The Johns Hopkins University School of Medicine.

Sheppard and Enoch Pratt Hospital

AMERICAN HEART ASSOCIATION

OCTOBER 21-27
ANNUAL MEETING
NEW YORK CITY

November 9-11
"Clinical Auscultation of the Heart"
a three-day postgraduate course
Georgetown University Hospitol, Washington, D. C.

November 11-12
Northeast Regional Conference
on
Cardiopulmonary Resuscitation and
Coronary Care Units
Holiday Inn, Baltimore

November 17-19
Conference on Work Evaluation Units
Washington, D.C.

ASSOCIATION OF MILITARY SURGEONS

November 7-9
ANNUAL MEETING
HILTON HOTEL, WASHINGTON, D.C.

BASIC ELECTROCARDIOGRAPHY

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University of Pennsylvania School of Medicine
PHILADELPHIA

FEES: A.C.P. Members, $ 60; Nonmembers, $100

"What The Internist Should Know About Cancer"
DECEMBER 5-9, 1966
Columbia University College of Physicians and Surgeons
NEW YORK CITY

FEES: A.C.P. Members, $ 60; Nanmembers, $100

For information, write: Edward C. Rosenow, Jr., MD, F.A.C.P., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104

MARYLAND PEDIATRIC SOCIETY

November 8, 8:00 PM

"Influence of Splenectomy on Childhood Infections"
(Illustrated)

J. Alex Haller, Jr., MD, Children's Surgeon-in-chief, Johns Hopkins Hospital.

1211 Cathedral Street, Baltimore

MARYLAND EAR, NOSE AND THROAT SOCIETY

November 8

Cocktails 6:30 PM, Dinner 7:30 PM, Meeting 8:00 PM

"Cryosurgery and Its Application to ENT Surgery"

Charles L. Hill, MD, Providence, Rhode Island.
Sheraton-Belvedere Hotel, Baltimore

PATHOLOGY SECTION, BCMS

November 21, 8:00 PM

Slide Seminar

William Hartmonn, MD, Surgicol Pothology Deportment, Johns Hopkins Hospital, Moderator.

"Studies in Kidney Hypertrophy and Peruvian Pathology"

Uriel Garcia-Caceres, MD, professor of Pothology, Cayetono-Heredia School of Medicine, Lima, Peru, ond exchonge professor, The Johns Hopkins University School of Medicine.

1211 Cathedral Street, Baltimore

AMERICAN MEDICAL ASSOCIATION

November 27-30

Clinical Convention
AND
National Conference on the Medical Aspects of Sports
Las Vegas

AMERICAN ACADEMY OF PEDIATRICS

October 22-27
ANNUAL MEETING
Polmer House, Chicago

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

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Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, AUGUST 4

1. Drs. William J. Peeples, State Health Commissioner, Edward Davens and Claude R. Dodson discussed means of facilitating communication between the Health Department and the Faculty.

2. State Health Department regulations for Nursing Homes, both Extended Care and Long Term Care, were approved.

3. At the request of the State Superintendent of Schools and the State Health Commissioner, the President was authorized to appoint a Faculty representative to the Joint Advisory Committee on School Health.

4. At the suggestion of the Treasurer, the Committee approved recommendation to the Council of an appropriation of up to $5,000 for the purchase of an accounting machine and related printed forms to increase the efficiency of bookkeeping and the accuracy of membership records.

EXECUTIVE COMMITTEE, SEPTEMBER 8

1. The following were approved for recommendation to the Commissioner of Motor Vehicles for appointment to the department's Medical Advisory Board: J. Sheldon Eastland, MD, James R. Karns, MD, and Paul F. Richardson, MD, Baltimore City, and Francis Carl Mayle, Jr., MD, Bethesda.

2. Miriam Van Gelder, MD, head of the Inpatient Program of the State Health Department's Division of Medical Services, conferred with the Committee on the Utilization Review of Extended Care Facilities throughout the State which is anticipated when the program becomes operative under Medicare Law.

3. In consideration of the State Health Commissioner's response to a July query addressed to the State Board of Health and Mental Hygiene, it was agreed that the Health Department has a standing invitation to attend any Executive Committee meeting to present material it considers important to the Faculty and that, reciprocally, the Committee would like to feel free to extend such invitations to Health Department representatives as it deems appropriate.

4. The Committee was advised that, according to the August 16, 1966, *Wall Street Journal,* Johns Hopkins Hospital plans to establish the position of Assistant Physician (formerly Senior Resident) and to bill government agencies for services rendered by such physicians. It was agreed that comments should be sought and an invitation to the next Committee meeting extended to informed staff members to discuss this.

5. A letter from Church Home and Hospital informed the Committee that its bylaws provide for staff appointments regardless of race.

6. The selection of a date for the next joint meeting of the Executive Committees of the Hospital Council and the Faculty was postponed pending receipt of a recommendation from the Faculty representative on the Areawide Health Facilities Council.

7. The Committee approved sponsorship of a meeting of Principal Nursing Home Physicians on the care rendered in nursing homes, and appointment of an ad hoc committee to develop a program for the meeting.

8. The resignation of Walter E. James, MD, as a Faculty representative on the Advisory Committee on Foster Care was accepted with regret and the President was authorized

to name a replacement.

9. Approval of the provision of staff assistance and space, without charge, for the Governor's Committee on Tuberculosis Control was granted, with the understanding that its study program would be completed within the next three months.

10. The President was authorized to appoint a Faculty representative to the Maryland Medical/Legal Foundation to replace Albert E. Goldstein, MD.

COUNCIL, SEPTEMBER 8

1. Present for the recommendation of the Fee Schedule Committee on budgetary figures for home and office visits under medical care programs (Title XIX of PL 89-97), and for the general discussion of this subject which followed, were representatives of the Advisory Council on Medical Care, the State Department of Health, the State Board of Health and Mental Hygiene, Maryland Medical Service and the Faculty's PL 89-97 Liaison Subcommittee. Subject matter encompassed the philosophies of the federal government in relation to payment for medical care, payment of fees to physicians so that receivers of service will benefit from the same standards as all recipients of medical care, and the need for education of legislators.

2. The Council unanimously adopted the following motion: "The Council requests the State Board of Health and Mental Hygiene to submit figures in the budget based on payment of the usual, customary and reasonable fees to physicians for services rendered under the medical care programs for the state; and that the figures provided by the PL 89-97 Liaison Subcommittee at its May 27, 1966, meeting be used as a working mechanism for preparation of budgetary figures only."

3. Physicians' defense was ratified for seven members, but denied to another because the incident occurred prior to application for membership in the Faculty.

4. Financial statements, covering both operating and restricted funds, were approved as presented.

5. The Council, on recommendation of the Executive Committee, authorized the expenditure of up to $5,000 for the purchase of an accounting machine and related printed forms.

6. Legal Counsel was reappointed for an additional year.

7. On recommendation of the Executive Committee, C. Thomas Flotte, MD, Baltimore City, was appointed Editor of the Journal, effective October 1, 1966.

8. The Council approved endorsement of the *CICHA Health Fair to be held in 1967, subject to established rules for Faculty participation in such a project and to no financial obligation on the part of the Faculty.

9. At the suggestion of the Baltimore City Medical Society, the Council voted to recommend to the House of Delegates Emeritus Membership in the Faculty for Victor Goldberg, MD, Baltimore City.

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cautions: As with all new drugs, blood and liver function tests are advis- during prolonged treatment. **Pending further experience, like most motherapeutic agents, this drug should not be given in the first trimester regnancy. It must be used cautiously in patients with liver disease or ere impairment of kidney function.** Because photosensitivity reactions have urred in a small number of cases, patients should be cautioned to avoid ecessary exposure to direct sunlight while receiving NegGram, and if a ction occurs, therapy should be discontinued. The dosage recommended adults and children should not arbitrarily be doubled unless under the ful supervision of a physician. Bacterial resistance may develop.

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erences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on uest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: microbial Agents and Chemotherapy—1964, Ann Arbor, American iety for Microbiology, 1965, p. 722.

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*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.



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EXECUTIVE SECRETARY'S NEWSLETTER

October, 1966

NIH PATIENT REQUEST

The National Institutes of Health has made known its need for patients as follows:

Hodgkin's Disease: patients with no previous treatment or minimal prior treatment. All clinical stages of biopsy-proven disease are acceptable. Major purpose of the study is to determine the curative potential of intensive radiotherapy in localized cases and to evaluate combination chemotherapy and x-irradiation in patients with generalized involvement.

Chronic Lymphocytic Leukemia: Referrals of selected patients, particularly those with high circulating lymphocyte counts, are needed. This is part of a continuing study of this disease, including therapy in patients with this disorder.

For further details, contact the Faculty office.

ALCOHOLISM FAIR

The Baltimore Area Council on Alcoholism is scheduling a Fair to be held at the Church of the Redeemer, October 27 and 28, from 3:30 p.m. to 6:30 p.m. The Faculty's Subcommittee on Alcoholism has endorsed this project in public education and urges physician attendance wherever possible.

PHYSICIAN MANPOWER

Increases in medical school enrollment and graduation are depicted below:

	1940	1965
Enrollment	21,271	32,428
Graduates	5,097	7,409

Planned expansion in 1967 will result in 992 additional places for medical students. In addition, at least 25 new medical schools are in the process of planning or construction. The State of Maryland has under discussion an additional medical school, although this is not included in the above figure of 25.

NEWS NOTES

E. Eugene Covington, M.D., has been appointed Senior Radiotherapist at Memorial Sloan-Kettering Cancer Center.

The Maryland Association of Private Practicing Psychiatrists has listed the following Committee Chairmen:

Program - Joseph D. Lichtenberg, M.D.
Membership - Frederick F. Converse, M.D.
Public Relations - Jonas R. Rappeport, M.D.

Irving Freedman, M.D., has assumed his duties as the first full-time Chief of Medicine at Lutheran Hospital, Baltimore. He was formerly in the same capacity at the VA Hospital, Fort Howard.

American Society of Anesthesiology has designated the following new members of that group from Maryland:

Junior Members: Drs. Ines Carmen Cilliani, Jai Sung Lee, Hector Cortes Mendez, Carlos Garcia Miller, all of Baltimore; Blair Mercer Barnett, Silver Spring; Jack Raymond Collins, Bethesda; and Edward Patrick Juras, Rockville.

Federal Associate Member: Robert Michael Oliverio, Jr., Annapolis.

Active Member: Edwin Joel Goldman, Baltimore

CONGRESS ON SOCIO-ECONOMICS OF HEALTH CARE

The American Medical Association has announced the first national congress on the Socio-Economic of Health Care in Chicago, on January 22 and 23 1967, at the Palmer House. Further details are available through the Faculty office.

AMA-ERF FUN(d) DAY

The Woman's Auxiliary will sponsor its annual AMA-ERF FUN(d) DAY, on Thursday, November 10, at the Faculty Building.

This annual event raises money for contribution to the American Medical Association Education and Research Foundation. Each local auxiliary participates by sponsoring a booth displaying wares for sale. Admission, which includes lunch, is $1.00. Hours - 11:00 a.m. to 3:00 p.m.

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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W. B. Saunders Company, 1959, p. 395.

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Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
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Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

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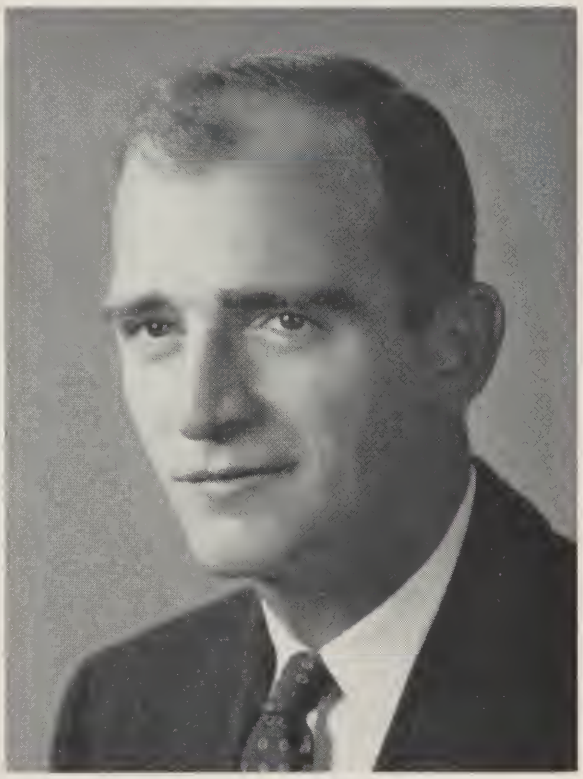
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Maryland State Medical Journal
Vol. 15, No. 10
October, 1966

THE *JOURNAL* CHANGES EDITORS



George H. Yeager, MD



C. Thomas Flotte, MD

"The advent of this publication represents the culmination of the hopes and efforts of the officer body of the Faculty."

These were the opening words of George H. Yeager, MD, in a FOREWORD to the January, 1952, issue of the *Maryland State Medical Journal* (Vol. 1, No. 1). The founder and first Editor of the *Journal,* Dr. Yeager had only begun his "efforts," however. He continued as Editor until October 1 of this year, when his resignation, accepted by the Council on June 9 with regret and with an expression of appreciation for his many years of service, became effective.

Dr. Yeager, who is also a past president and secretary of the Faculty, is professor of Clinical Surgery at the University of Maryland School of Medicine and director of Professional and Supporting Services at the University Hospital.

He is editor of *The American Surgeon,* chairman of the Planning Council for the State Board of Health and Mental Hygiene, secretary of the Southern Surgical Association, and a member of many other medical societies.

An alumnus of the University of West Virginia, Dr. Yeager was graduated from the University of Maryland School of Medicine in 1929 and completed the four-year Surgical Residency Program at the University Hospital in 1933. He became a diplomate of the American Board of Surgery in 1940 and in 1942 began three and one-half years of military service in the Pacific. During part of that period he was the commanding officer of the 42nd General Hospital. He was awarded the Legion of Merit in 1945 and is presently serving as a surgical consultant to the Surgeon General, U.S. Air Force, with the rank of Brigadier General.

Dr. Yeager is the author of more than 60 published papers. He is married to the former Dorothy Stone and they have three children.

Dr. Flotte Second Editor

C. Thomas Flotte, MD, co-chief of the Department of Surgery and Director of Education at the University of Maryland, succeeds George H. Yeager, MD, this month as Editor of the *Journal.* He is on the staffs of the University Hospital and Maryland General Hospital.

A diplomate of the American Board of Surgery, Dr. Flotte is also a consultant to the U.S. Public Health Service in Baltimore and to the National Institute of Health in Bethesda.

Graduated from Franklin and Marshall College in 1943, he received his MD from Jefferson Medical College in 1946. Following his internship at Jefferson Hospital, he served for two years with the U.S. Navy Medical Corps in the South Pacific. After one year of residency at Washington Hospital and an additional four years at the University of Michigan Hospital, from 1954 through 1959 he was first an instructor and then an assistant professor in surgery and in postgraduate medicine at the University of Michigan. During that period he was also on the staff of the University of Michigan Hospital and affiliated with the V.A. Hospital in Ann Arbor and the Northville and Ypsilanti State Hospitals.

Dr. Flotte is the author of numerous articles on a wide variety of subjects, notably vascular disease, a special field of interest. He is also a member of many medical societies, local, state and national.

He and his family moved to Baltimore in January, 1960. He is married to the former Harriet Shand and the father of three children.

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All scientific exhibits accepted for showing at the 1967 Annual Meeting will be eligible for judging. As space in the exhibit hall is limited, applications should be sent promptly. Physicians interested should contact the chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

ANNUAL MEETING

APRIL 19, 20, 21, 1967

Baltimore



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It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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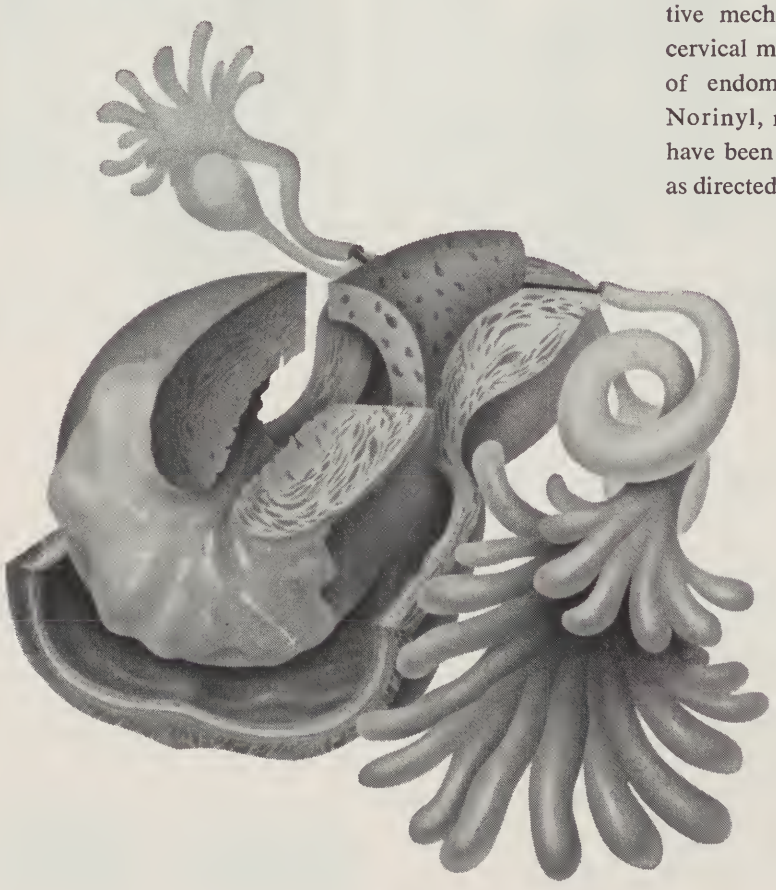
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for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

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no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

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Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

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An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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ORAL DRUGS IN THE TREATMENT OF DIABETES MELLITUS

DeWITT E. DeLAWTER, MD
Clinical Associate Professor of Medicine
Georgetown University School of Medicine

The oral agents available for the treatment of diabetes mellitus are divided into two groups, the sulfonylurea group and the biguanide group. Of the sulfonylurea group, the three agents available are tolbutamide (Orinase), acetohexamide (Dymelor), and chlorpropamide (Diabinese). Tolazimide (Tolinase) will probably be available shortly. In the biguanide group the only agent available commercially is phenformin hydrochloride (DBI).

The first part of this discussion will be limited to the sulfonylurea group. The indications for the use of these drugs are:

1. Onset of diabetes after 30 years of age,
2. Absence of ketonuria,
3. Absence of severe symptoms, and
4. Approximately normal weight.

The contraindications for the sulfonylureas are:

Absolute:

1. Ketoacidosis

Relative:

1. Juvenile patients,
2. Classical diabetic symptoms,
3. Pregnancy,
4. Surgery or other stress, and
5. Hepatic and/or renal disease.

The relative group is so classified because there are instances in which the patient may respond satisfactorily in this category.

The mechanism of action of the sulfonylurea drugs may be considered grossly to be increased production of and increased release of insulin from the beta cells of the pancreas.

The sulfonylurea drug with which we have had approximately ten years' experience is tolbutamide. It is rapidly oxidized to an inactive metabolite; 75% of it is excreted within 24 hours and it has a blood half-life of approximately six hours. It is marketed in a tablet of 0.5 gm. The average dose is 1.5 gm/day, with a maximum dose of 3.0 gm/day. Administration is usually divided into two doses per day.

The second of the sulfonylurea drugs is acetohexamide. It is rapidly reduced to an inactive metabolite; 15% of it is excreted in 24 hours. It has a blood half-life of six plus hours. It is marketed in dosage forms of 0.25 gm and 0.5 gm. The average dose per day is 0.75 gm, with a maximum dose of 1.5 gm. This, too, is usually divided into two doses per day.

Chlorpropamide is not metabolized; 25% of it is excreted unchanged in 24 hours. It has a blood half-life of 30 to 36 hours. It is marketed in dosage forms of 0.1 gm and 0.25 gm. The usual dose is about 0.25 gm, with a maximum dose of

Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 22, 1966.

From the Department of Medicine, Georgetown University School of Medicine, Washington, DC.

0.75 gm. It is given as a single dose each day. An occasional disulfiram (Antabuse) flush-type reaction may occur with the drug.

Tolazimide is 85% excreted in the urine and has a blood half-life of seven hours. It is provided in dosage forms of 0.1 gm and 0.25 gm. The average daily amount is 0.5 gm and is usually divided into two doses daily. The maximum amount recommended is 1.0 gm/day.

Failure to respond to the oral agents has been generally divided into two classes: primary failure and secondary failure. Primary failure indicates no degree of satisfactory control of blood sugar levels with trial periods of up to one month. Secondary failures are those patients having satisfactory control for at least one month followed by unsatisfactory control in spite of maximum acceptable dose of drug used. Satisfactory control is indicated by little or no glucosuria and ability to maintain a blood sugar level below 190 mg/100 ml.

If properly selected patients are included in a series, the usual rate of primary failure is about 20%. The rate of secondary failure will be related to the degree of selectivity used for the series and the duration of the therapy. In one group of 200 patients treated with tolbutamide, the following cumulative rate of secondary failure was observed.[1, 2]

One year	16%
Two years	27%
Five years	36%
Ten years	40%

After five years there were still 26 (13%) patients out of the initial group of 200 taking tolbutamide. After ten years there were 13 (7.5%) taking the drug.

A comparison of primary and secondary failure rates for three agents—tolbutamide, chlorpropamide, and phenformin—after two years of trial, is shown in Table 1. It does not show acetohexamide because there has not been enough experience with this drug to be statistically significant. Both tolbutamide and chlorpropamide have a primary failure rate of approximately 20%; however, the secondary failure rate after two years of observation is 27% for tolbutamide and 12% for chlorpropamide. Note that emphasis is placed on two years of therapy because: the shorter the period studied, the less the degree of secondary failure, and the longer the period studied, the greater the degree of secondary failure. In the phenformin group there is a great amount of primary failure (31%) because of the high incidence of side effects with the use of this agent.

Table 1

A Comparison of Primary and Secondary Failure Rates of the Three Hypoglycemic Agents

Drug	Primary Failure %	Secondary Failure %
Tolbutamide	21	27
Chlorpropamide	18	12
Phenformin	31	12

The relative initial response to the incidence of secondary failure is shown in Fig 1. It is noted that the patients who demonstrate the best initial response are less apt to develop secondary failure. Those who show marginal or borderline control are more apt eventually to develop secondary

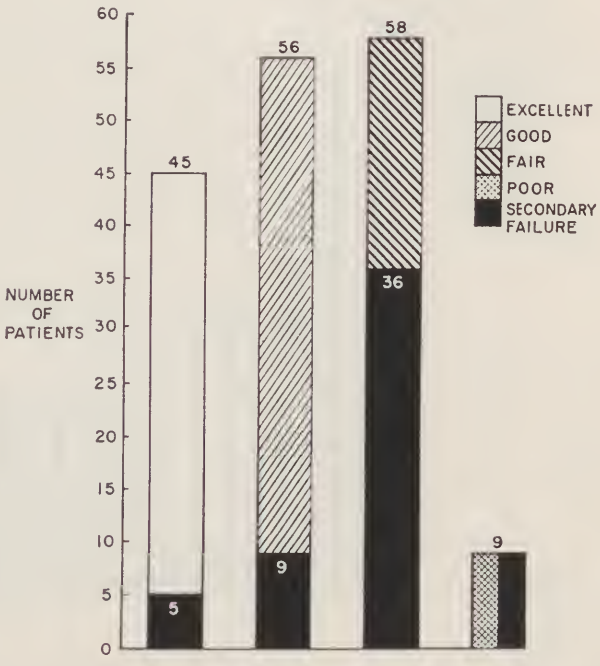


Fig 1

Effect of initial response of patients who developed secondary failure of response to tolbutamide.

failure. By excellent results is meant a blood sugar level of 120 mg/100 ml (Folin-Wu) or less; good results are approximately 150 mg/100 ml or less, and fair results 170 mg/100 ml or less. Failure is considered to occur when a patient cannot maintain the blood sugar level beneath 190-200 mg/100 ml.

A study was made on a group of 35 patients of the insulin requirements before and after tolbutamide trials (Fig 2). Twelve patients required more insulin before than after the trials; 15 required less before than after the trials with the oral agents, and 8 required the same amount. Therefore, it was concluded that the secondary failure was not due to a worsening of the diabetes since it did not demonstrate an increased requirement for insulin after the trial with sulfonylurea therapy.

The results of a group of 25 patients who developed secondary failure to tolbutamide is illustrated in Fig 3. They were then placed back on insulin for approximately six months and tried again on tolbutamide. The solid bars indicate the duration of the first trial, and the hatched bars demonstrated the duration of the second trial. It is noted that one patient obtained a successful second response for as long as eight months but eventually failed. It is concluded from this that patients who are secondary failures to the sulfonylurea agents may again be tried on the same sulfonylurea agent after a rest period on insulin therapy, but in each instance they will fail again with a lesser duration of successful therapy than the first time. This may also explain why an occasional patient will respond briefly to a less potent sulfonylurea agent after secondary failure

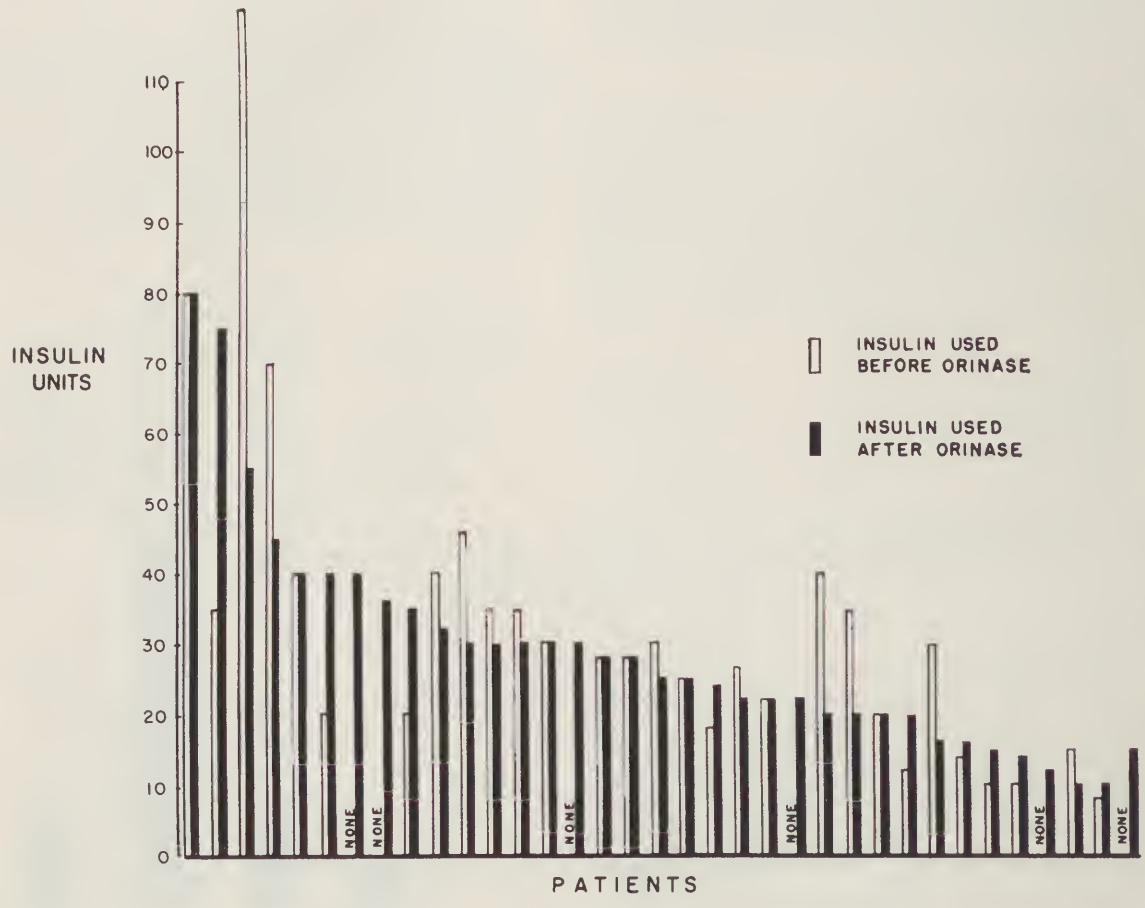


Fig 2

Insulin requirements of 35 patients before tolbutamide treatment and after secondary failure of response.

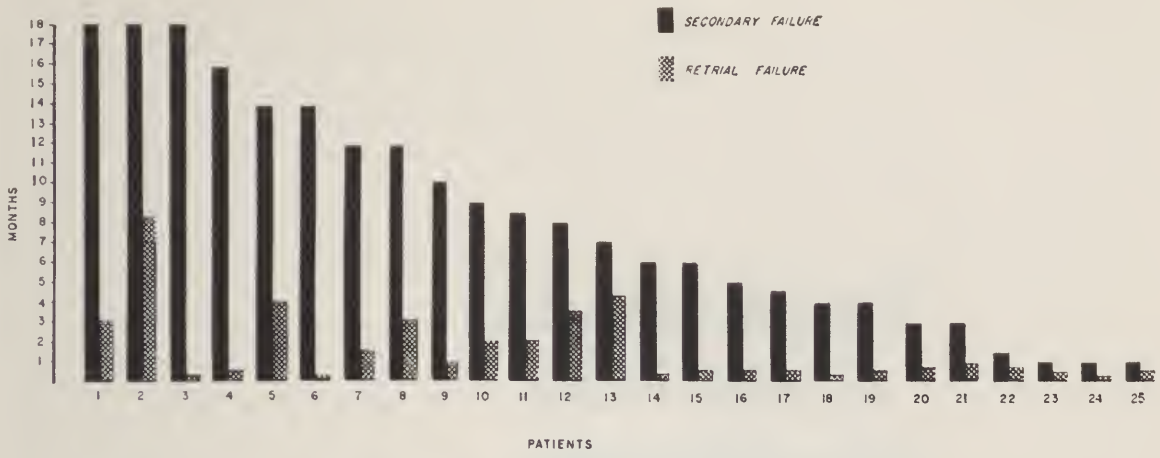


Fig 3

Duration of satisfactory responses in patients given retrial on tolbutamide subsequent to a rest period after secondary failure.

to a stronger one.

A placebo method of therapy was given to 27 patients with secondary failure to tolbutamide and the 27 patients failed. Twenty-five patients were retried on tolbutamide and all failed. Thirty-four secondary failures to tolbutamide were tried on chlorpropamide; 20 failed and 14 were successful. We attributed the effectiveness of the drug to its increased half-life and lesser rate of excretion of chlorpropamide. Twenty-three secondary failures to tolbutamide were tried on phenformin. Of these, 9 were failures and 14 responded. Phenformin has a different mode of action. The failure to respond to one of the sulfonylureas should be neither an indication for nor against the person's effectiveness with phenformin.

The effect of placebo and tolbutamide on six obese diabetic patients is shown in Fig 4. On the left side is the blood sugar scale of six patients treated with four weeks of diet alone with the maximum-minimum blood sugar levels, followed by four weeks of placebo and diet, and then four weeks of diet plus tobutamide. On the right side are shown the weights of the same patients on the four weeks of diet alone, followed by four weeks of placebo plus diet, and four weeks of tolbutamide plus diet. Weight control, as illustrated by the bars on the left side, demonstrated the placebo to be more effective than tolbutamide and emphasizes what has been known for a long time, that weight control is very helpful in control of the blood sugar level of the obese patient. It is really more

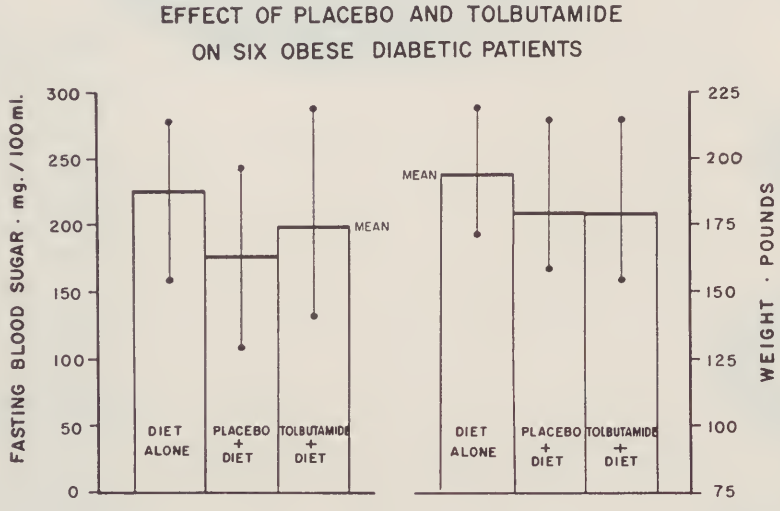


Fig 4

Comparative effect of a placebo and tolbutamide on blood sugar levels and weight of six obese patients.

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials — usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction, extensive ulceration of bowel, or diverticulosis; in hypersensitivity to sulfonamides or neomycin; in pregnancy at term, in premature infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients with hepatic or renal damage, urinary obstruction, or blood dyscrasias. Fatal hypersensitivity reactions and blood dyscrasias reported with use of sulfonamides. Consider periodic blood counts, hepatic and renal function tests during intermittent or chronic use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if there is history of significant allergies and/or asthma. Continued use requires supplementary vitamins B_1 and K. *Neomycin:* Watch for

your ℞ for Cremomycin can provide relief



curare-like neuromuscular block during anesthesia if neomycin is used preoperatively in large doses when renal function is poor; watch for overgrowth of nonsusceptible organisms. Consider possibility of ototoxicity and nephrotoxicity with prolonged high dosage.

SIDE EFFECTS: As with all sulfonamides: Headache, malaise, anorexia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, rash, conjunctival and scleral injection, petechiae, purpura, hematuria, and crystalluria have been noted. Reduced fecal output of thiamine and decreased synthesis of vitamin K have been reported. *Neomycin:* Nausea, loose stools.

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important than any of the oral agents.

Patients who are not successful with sulfonylurea therapy, or have developed secondary failure and are not successful on phenformin therapy to maximum dosage, often will show improvement on combination therapy of chlorpropamide plus phenformin. We have had 31 of 46 patients tried on such a combination who were successful. The dose is usually 0.5 gm chlorpropamide and 0.1 gm phenformin hydrochloride—in a timed-disintegration capsule (TD). Very occasionally, insulin plus phenformin is used to assist in the stabilization of a brittle diabetic.

If the patient requires insulin, he should have an adequate dose of insulin and no sulfonylurea therapy.

Table 2 has been compiled to show the comparative daily costs of hypoglycemic agents. It is self-explanatory. Of course, 70% of diabetics are overweight and could possibly be controlled on diet alone. Of the sulfonylurea drugs, the cheapest average daily dose is chlorpropamide. If combination therapy is used, it becomes quite expensive.

Table 2

Daily Costs of Hypoglycemic Agents

Drug	Amount	Cost
Insulin	40 Units	$ .15
Tolbutamide	1.5 gm	.27
Acetohexamide	1.0 gm	.18
Chlorpropamide	0.25 gm	.14
Phenformin TD	0.1 gm	.24
Combination		
Chlorpropamide	0.5 gm	.28
Phenformin TD	0.15 gm	.36

Cost is of considerable importance to these patients because of the long period of time in which they take the drug.

The other oral agent group not previously discussed is the biguanide group of which phenformin hydrochloride is the example. Indications for use of this drug are overweight adult diabetics, nonketotic adults who do not respond to sulfonylurea drugs, and in combination with the sulfonylureas when there is a poor response form each drug used alone.

Phenformin increases the glucose uptake in the muscles. Its metabolic rate is unknown. The duration of activity of tablets is perhaps three to six hours and the TD capsules, 8 to 16 hours. Dosage form is tablets of 0.025 gm and TD capsule of 0.05 gm. Minimum dose is 0.025 gm; average dose is about 0.125 gm to 0.15 gm, and maximum dose is 0.3 gm or to tolerance. It is usually divided into two or more doses daily. The results in 177 patients treated with phenformin are: satisfactory 56%, unsatisfactory 42%, other 2%. As the dose is increased, the side effects become relative to this increase.

The criteria for control to be strived for in the treatment of diabetes are:

1. Relief of symptoms of diabetes.
2. Avoidance of hypoglycemia.
3. Maintenance of normal weight.
4. Absence of glucosuria.
5. Blood sugar levels between 80-130 mg/100 ml before each meal.

If excellent control can be achieved with a sulfonylurea drug, with phenformin, or with a combination of the two, this is the treatment of choice. If it cannnot be achieved with an oral agent, the physician should not hesitate to advise the use of insulin and discontinue inadequate control with oral agents.

3848 Porter Street, NW
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GENERIC AND TRADE NAMES OF DRUGS

Acetohexamide—*Dymelor*
Chlorpropamide—*Diabinese*
Phenformin hydrochloride—*DBI*
Tolazimide—*Tolinase*
Tolbutamide—*Orinase*

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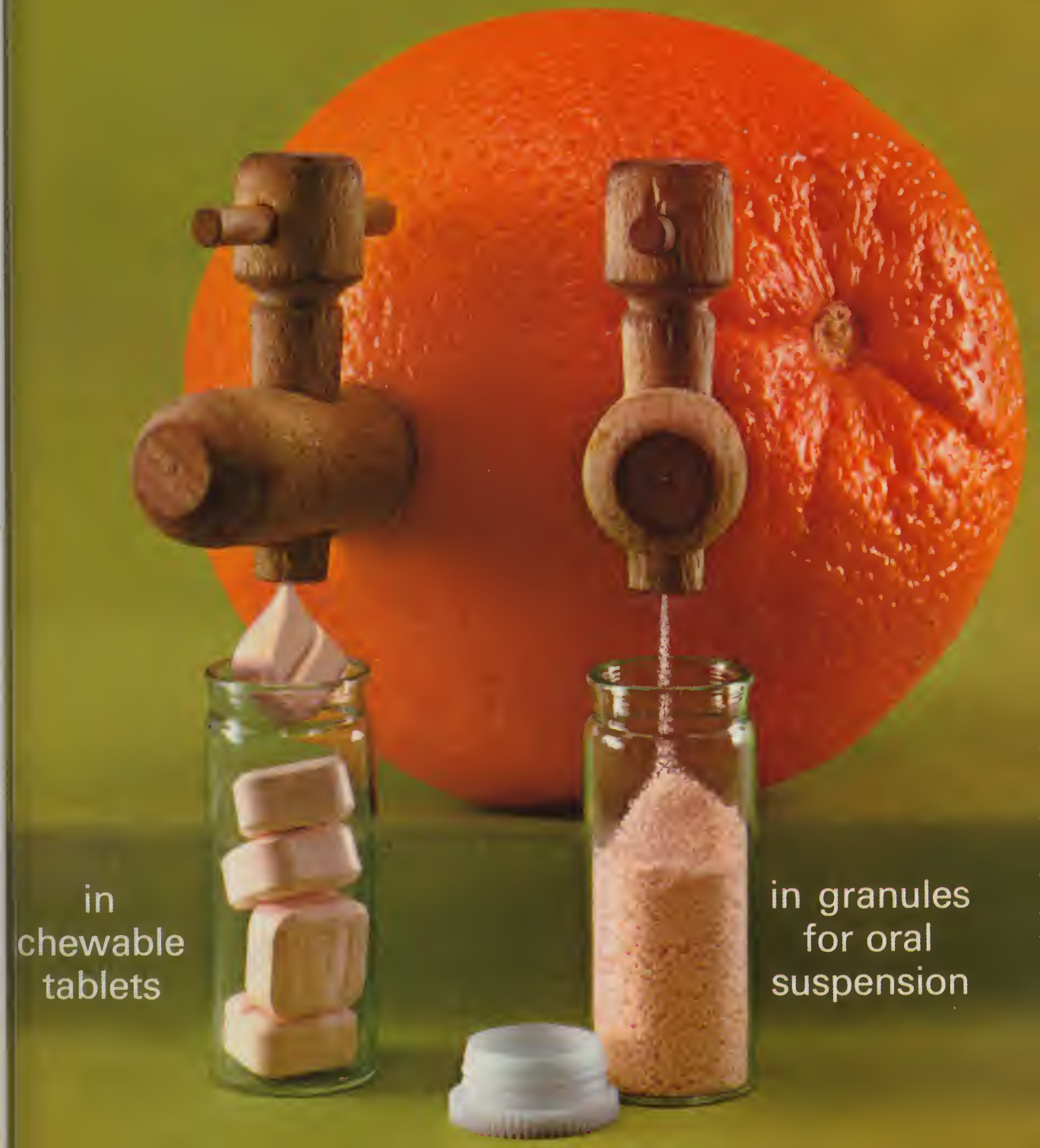
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2. Unpublished data.

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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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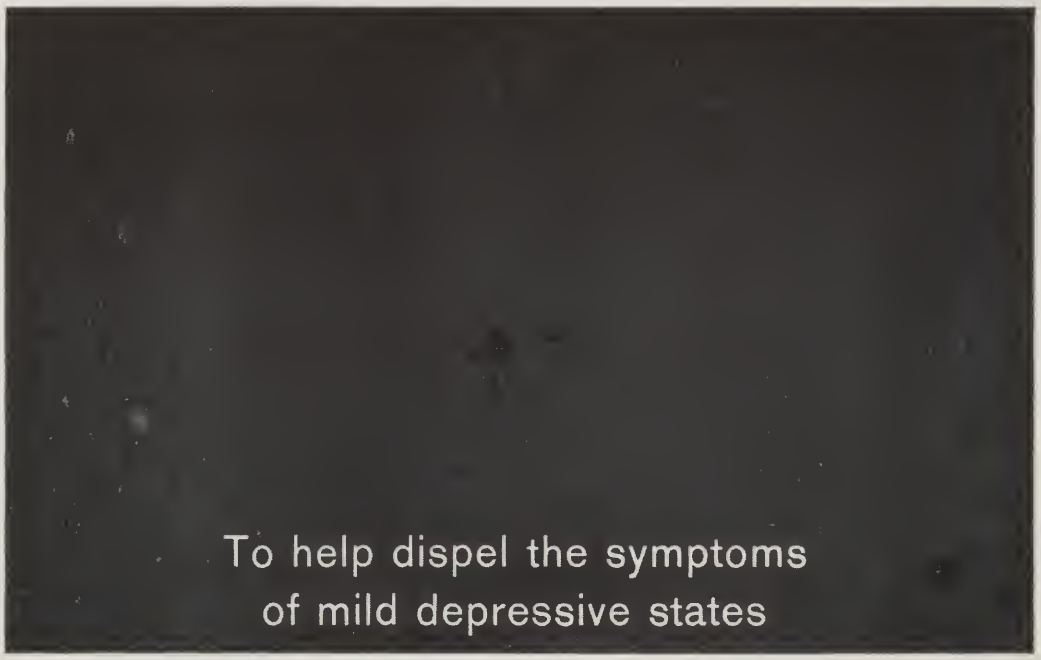
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Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

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DIABETES-OBESITY: A NEW CONCEPT AND ITS MANAGEMENT

S. K. FINEBERG, MD, FACP
Clinical Associate in Medicine, New York Medical College; Visiting Physician, Harlem Hospital, New York City

Linking the two conditions obesity and diabetes with the term "obesity-diabetes" in the past has been done infrequently and casually. Possibly it has been used more often by myself than by others. About five or six years ago I attempted to emphasize the importance of the association by the initiation of a special clinic, the Obesity-Diabetes Clinic, for problems of this nature. Recently a rapid accumulation of evidence has given this hyphenation a new twist and a deeply significant meaning. It now seems probable that the obesity which is present in possibly as many as 85% of the older, maturity-onset diabetics is not "the most important precipitating and aggravating factor" of their disease. On the contrary, the obesity which precedes diabetes may be caused basically by the same inherited genetic defect which produces the clinically detectable impairment of carbohydrate metabolism. This new concept indicates that the obesity is actually an earlier stage of diabetes which may be present for many years prior to the development of carbohydrate tolerance. To put it simply; *The patient did not become diabetic because he was obese. He became obese because he was diabetic!* What appeared to be the principal cause (obesity) producing the effect (diabetes) is now being viewed as a manifestation of the developing clinical disease. For this reason (and I hope this does not add to the confusion of terms with which the explosion of knowledge in the field of diabetes has burdened us), I think it would be more appropriate to call this entity diabetes-obesity, at least in its premellitic if not in its postmellitic phase. It might be descriptive of the situation to speak now of "fat-diabetes" in which the clinical state is more one of abnormal fat metabolism in distinction from the later stage in which carbohydrate metabolism appears to be most disturbed.

The hypothesis that obesity can be a prediabetic or premellitic phase of diabetes is supported, among other evidence, by the repeated demonstration of increased levels of circulating insulin and insulin-like activity in obese subjects who subsequently develop diabetes and of normal to elevated levels of insulin and insulin-like activity in most obese diabetics. These findings have been adequately confirmed. Recently, Berson and Yalow have even suggested a classification of diabetes based on "high output" and "low output" of insulin. In this useful concept the nonketotic, maturity-onset diabetic and *obesity per se* are classified by them as high-output forms of diabetes. *Indeed, it now seems highly unlikely that any overweight diabetic could be suffering from insulin deficiency*, or as it is called, "insulinoprivic" diabetes.

Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 22, 1966.

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.







"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

Pathogenesis

Currently the most appealing theory of the pathogenesis of most diabetes is that it is due to an enzymatic defect in the biosynthesis of insulin with the compensatory overproduction of an abnormal, biochemically less active form. Although this may be abnormal insulin in that its effect on the transport of glucose into the cell is impaired, it is either normal or more active than normal in regard to fat synthesis and deposition. In the months or years preceding the loss of pancreatic ability to compensate for defective insulin formation, an insulin-effected lipogenesis produces obesity. Proportionately little diabetes is due to an actual deficiency or relative deficiency of insulin. The greater portion is due to a lack of effective insulin action stemming from one or possibly several different causes.

Establishing the cause as genetic may tend to eradicate the stigma of gluttony and diminish the feeling of guilt which many obese diabetics have about their obesity. It may also be reassuring to physicians to know that this form of obesity is not psychogenic in origin and, consequently, may respond more readily to therapy. The altered relationship of obesity from a cause to a concomitant manifestation of diabetes does not and should not change the fundamental therapeutic approach to this form of disease. The observation that weight reduction improves impaired carbohydrate metabolism and that the restoration of normal weight often makes diabetes no longer detectable by currently available diagnostic methods is as valid today as when it was first made more than 25 years ago. Latent, subclinical, even frank, diabetes can be, and often has been, reversed by this means alone to the premellitic or prediabetic phase. It is the only treatment of diabetes which can produce a remission with any degree of consistency. The mechanism through which this is accomplished may be through the restoration of a state of compensation or of sensitivity to impaired endogenous insulin action.

Management

The treatment of choice of diabetes-obesity, then, is weight reduction. The clinical axiom that the primary therapeutic target in this disease is the obesity remains unchanged and unchallenged. Insulin or oral hypoglycemic drugs should not be used until every effort has been made to control the diabetes by this means alone over a period of at least several weeks. Immediate control is not urgent since most of these ketosis-resistant diabetics have had considerable hyperglycemia and glycosuria for many months. It is more important for the newly discovered diabetic to see his glycosuria decrease, then disappear entirely, as he loses 10 to 15 pounds. The proper treatment of his condition will then be firmly fixed in his mind forever.

A simple diet of mixed nutrients chosen from the four basic food groups and calorically restricted through the use of small portions, estimated by household measurements, is recommended. This diet should be carefully reviewed with the patient as he is started on a "course" of education in good nutrition and caloric dietetics. This may loom as a difficult task to many physicians because although formal medical education is well-founded in the biochemistry of nutrition, it is usually lacking in its practical application. The patient must learn from his physician what the essential food groups are and the approximate caloric value of everything he eats. Successful education of the patient also requires his acceptance that this new way of life has to be permanent. Obesity, whatever the cause, is a disease which can only be controlled, it cannot yet be cured. Without mental adjustment to these facts, the lifetime control of diabetes-obesity, as well as obesity per se, is not possible.

During the early stages of education and mental adjustment, a specific mode of appetite control may be helpful. Anorexigenic medication, skillfully used, produces chemical control of the appetite center and symptomatic relief of hunger. The standard and leader in the field of anorexigenic agents is phenmetrazine hydrochloride (Preludin), with dextroamphetamine almost as potent and as well-tolerated. These drugs seem to be particularly useful in diabetes-obesity because of its nonpsychogenic origin. A careful explanation of their sole purpose as symptomatic relief is imperative to avoid diverting the patient from his diet education to excessive reliance on medication.

Recently, it has been especially noted that in more than 60% of women a negative caloric intake below that needed for maintenance will produce a reduction in scale-weight for the first few weeks or months only. Although the fat content of these women is actually decreasing, the

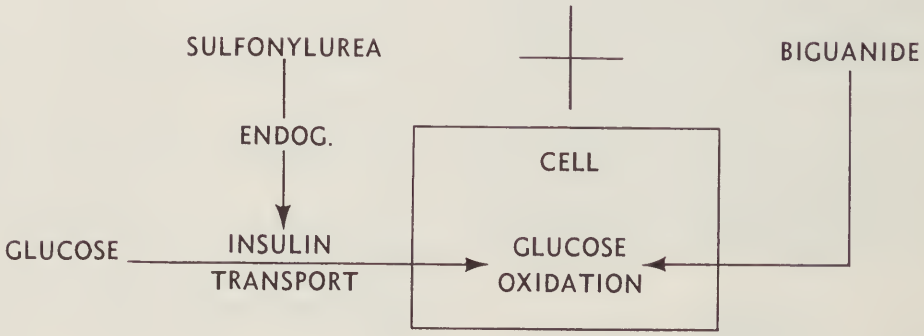
development of water retention counterbalances the fat loss and effectively masks it. This metabolic abnormality, whose cause is still unknown, is less transient and far more common than previously believed. Its detection and correction with diuretics is often essential to long-term successful weight reduction.

Oral Hypoglycemics

The proper indication for turning to a therapeutic trial of oral hypoglycemic drugs is *diabetes which is uncontrollable, not simply uncontrolled, by diet alone.* However, if weight loss is not being effected in the obese diabetic and glycosuria is excessive, the biguanide, phenformin hydrochloride (DBI), may be tried alone at first. The use of any oral hypoglycemic drug in this situation is not a therapy of choice but of concession or defeat. The enhancement of intracellular oxidation of glucose by phenformin in the *absence* of insulin-stimulated increased glucose transportation into the cell is usually not sufficient to control the diabetes. Consequently, the addition of sulfonylurea of often required. It is probably better to *add* a small dose than switch to sulfonylureas alone to minimize the lipogenic effect of their endogenous insulin release.

The combination of chlorpropamide (Diabinese) with phenformin affords the most potent oral hypoglycemic action available today. Combined therapy should probably be tried in all new diabetics of any age if they appear to be of the high-output type and are not in serious difficulty, before turning to insulin therapy. In the insulin-insensitive, often insulin-resistant, obese diabetic, the use of insulin is even less appropriate than oral hypoglycemic drugs. Injecting insulin adds an exogenous source of this lipogenic hormone to already increased levels of circulating endogenous insulin. What follows is first a discouraging, undesirable weight gain and then an increasing insulin requirement. The latter effect appears to be due to development of a significant amount of insulin-binding antibodies. Unfortunately, the obese diabetic seems to be particularly predisposed to the antigenicity of injected nonhuman insulin sources.

Many obese diabetic patients have been observed with fasting blood sugar levels of 300 to 400 mg/100 ml without acidosis while receiving 50 to 150 units of isophane insulin suspension (NPH insulin) daily! Instead of increasing their insulin, these individuals should be given a trial of combined chlorpropamide-phenformin therapy without any insulin at all. The combination frequently produces immediate and satisfactory control. As indicated, the sulfonylurea stimulates the output of less antigenic, endogenous insulin and the biguanide enhances glucose oxidation (Fig). The large amount of exogenous, more antigenic, lipogenic insulin needed in these cases to exceed the insulin-binding capacity of the serum and provide a small amount of free, unbound, active insulin may thus be entirely replaced by oral drugs.

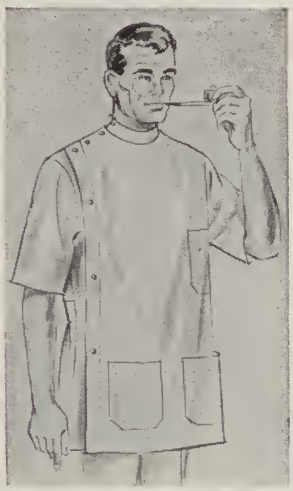


Suggested synergistic action of combined oral hypoglycemic drugs in enhancing glucose metabolism.

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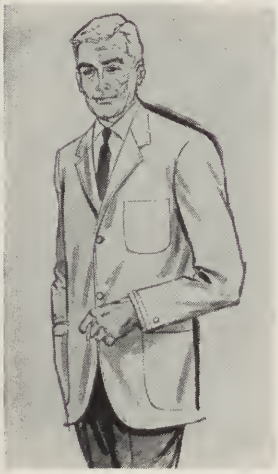
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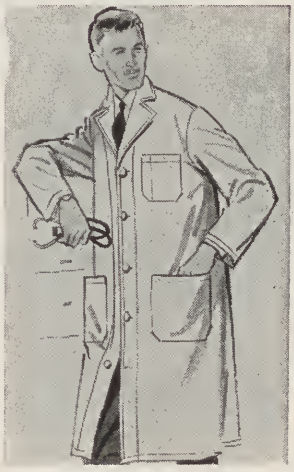
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The clinical application of these concepts is obvious and practical and has already been tried. All obese diabetics receiving insulin should be re-evaluated to decide whether attempting substitution of combined oral therapy for insulin is warranted. Under careful observation many of these patients can be safely converted from unnecessary, and to them, at least, possibly harmful, insulin therapy.

Definition and Summary

The recent explosive accumulation of new knowledge calls for the frequent redefinition of diabetes. At this moment a total concept of the disease in summary, which includes and indicates the status of diabetes-obesity may be stated as follows: *diabetes is a genetically determined and transmitted defect in carbohydrate metabolism, detectable by current diagnostic methods, often preceded or accompanied by microangiopathy, obesity, or other evidence of a premellitic phase and produced by a lack of effective insulin action.*

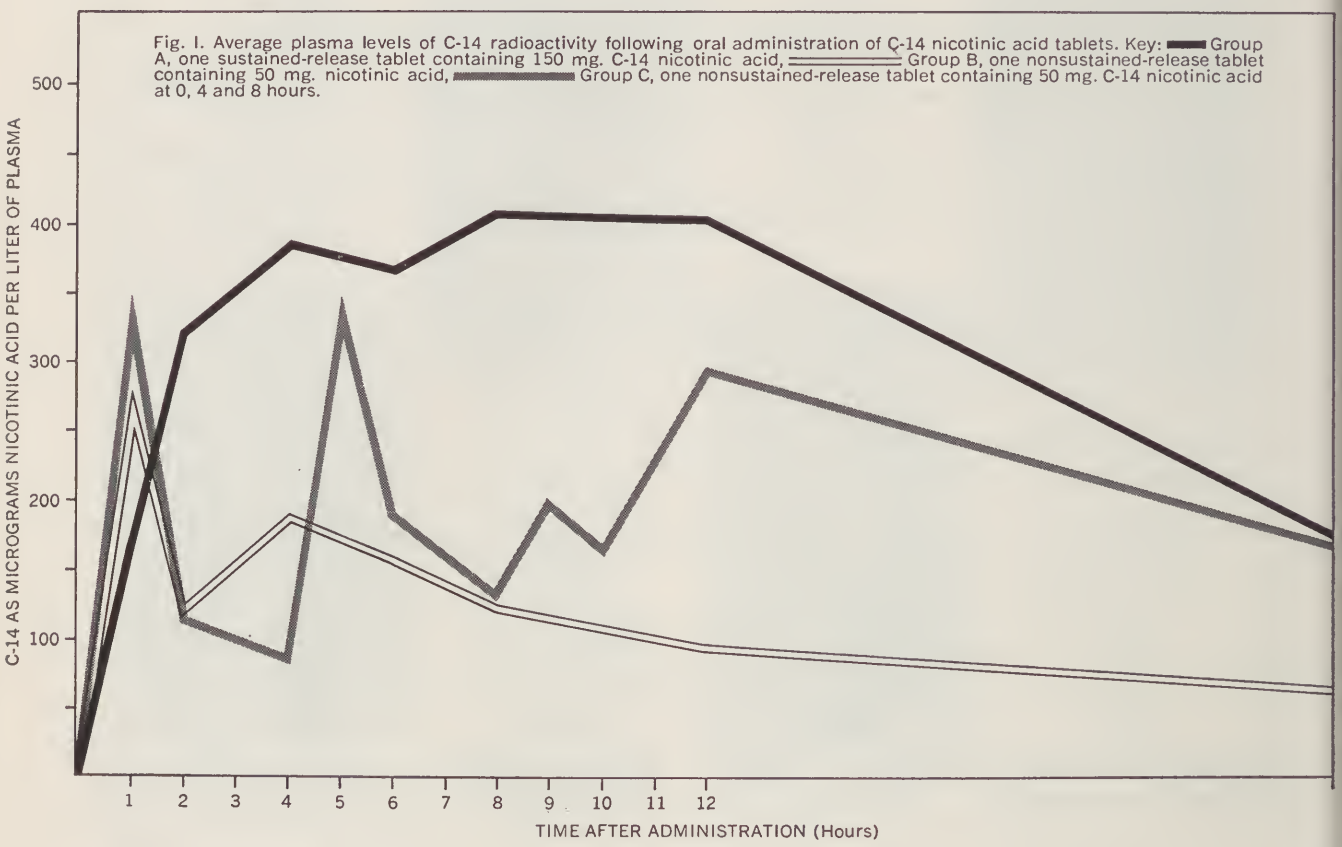
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GENERIC AND TRADE NAMES OF DRUGS

Chlorpropamide—*Diabinese*
Dextroamphetamine—*Dexedrine*
Isophane insulin suspension—*NPH insulin*
Phenformin hydrochloride—*DBI*
Phenmetrazine hydrochloride—*Preludin*

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

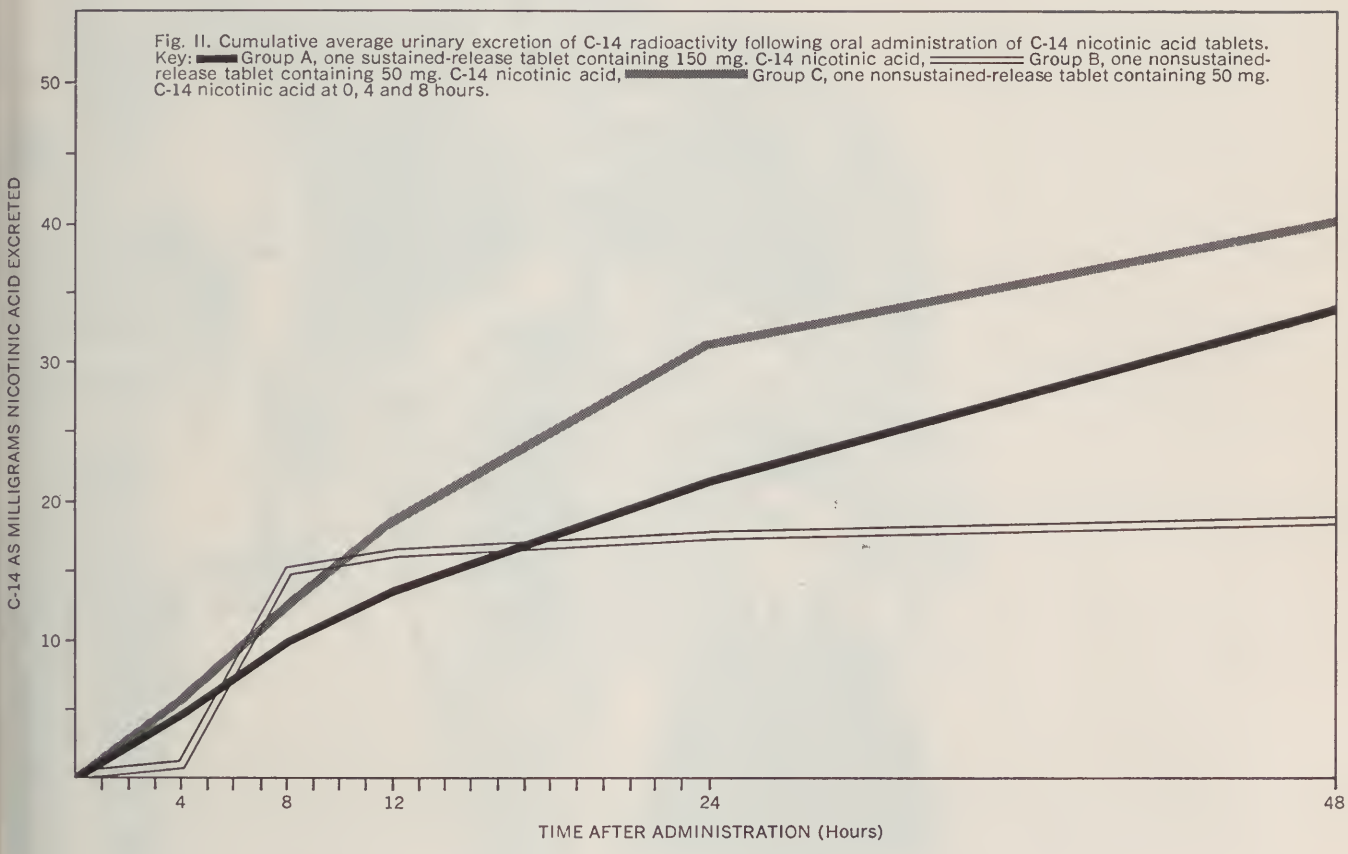
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

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less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

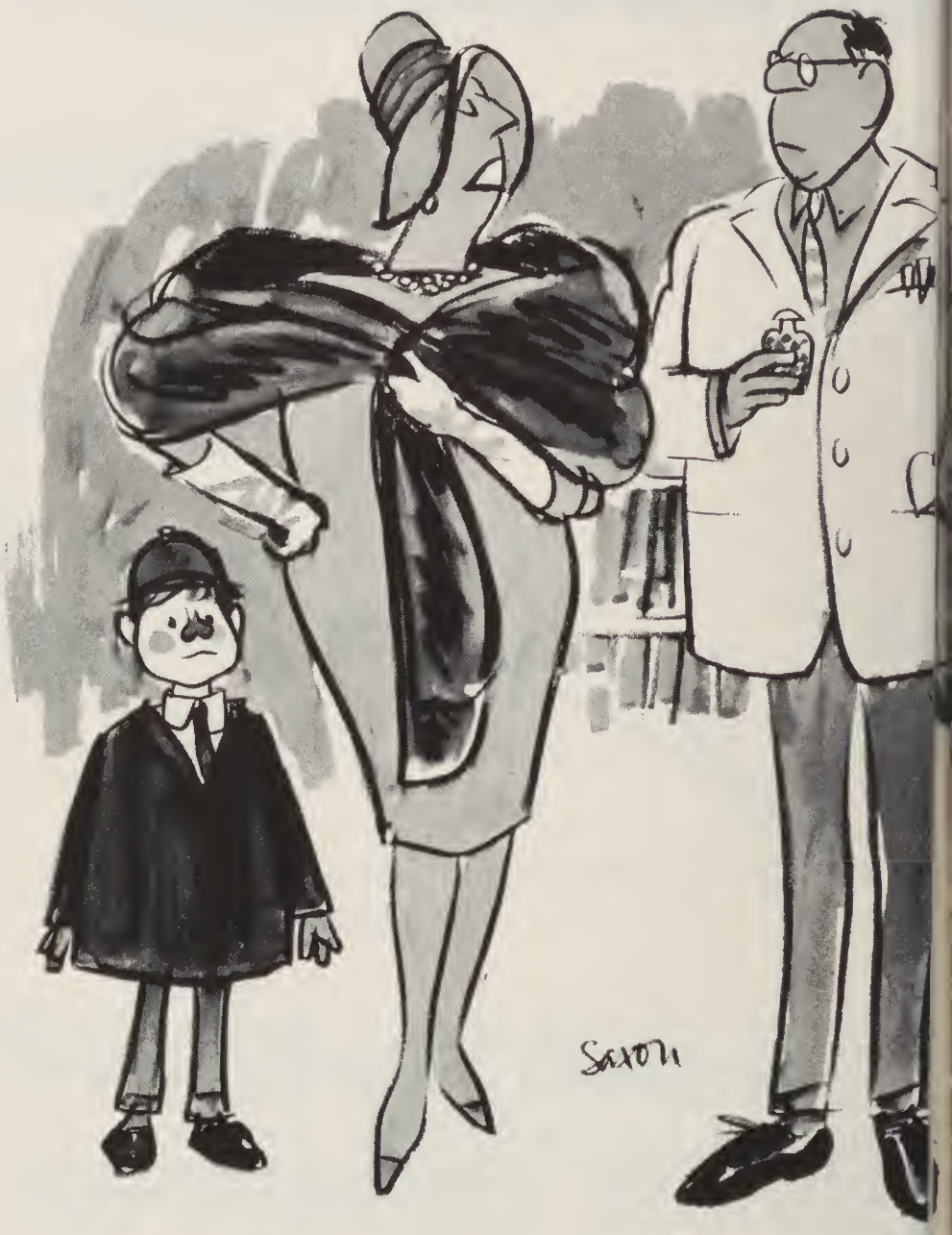
Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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COMPLICATIONS IN THE USE OF ORAL HYPOGLYCEMIC AGENTS

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The complications associated with the use of any therapeutic modality become extremely important factors, since certainly the treatment must not be more serious than the disease, and the newly contemplated therapy, if more advantageous, must be reasonably as safe as that which is already available. In diabetes we have a most wonderful drug, namely, insulin. Insulin has withstood the test of time and is uniformly therapeutically successful under all conditions. It is associated with virtually no toxic reactions. Therefore, we have a right to expect considerable safety in the use of oral agents, even though they offer the highly desirable feature of not requiring daily or, at times, even more than daily injections with a needle and syringe.

One can state categorically that the complications associated with oral therapeutic agents in clinical use today are remarkably minimal and mild. These drugs are essentially safe and are associated with few reactions of any consequence.

I think it pertinent to stress that they are not effective in all instances, and one must be alert to prevent the possible complication of ketoacidosis in these cases. Even when one can anticipate a high degree of success, there still are some primary failures, defined as those who do not respond to the drug before three to six months have elapsed, and secondary failures, which may be defined as those diabetic patients who no longer respond after a satisfactory initial response of six to twelve months' duration. The incidence of secondary failure is reportedly higher with tolbutamide (Orinase)[1] than with chlorpropamide (Diabinese). The treatment for this is to change to another of the oral agents to combine a sulfonylurea with phenformin hydrochloride (DBI), or both. If the response still is unsatisfactory, the patient is reverted to treatment with insulin.

Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 22, 1966.

From the Department of Medicine, Mount Sinai Hospital, New York, NY.

Hypoglycemia

The primary therapeutic effect of these drugs is to combat hyperglycemia. As a consequence, an abnormal hypoglycemia may be a problem. Any of these drugs may cause hypoglycemia which is usually short-lived and easily controlled. However, there is a small incidence of a serious reaction which does not appear to be dose related. This rare eventuality occurs almost exclusively in the elderly diabetic who has recently undergone a period of weight loss and is debilitated. In these instances, relatively minute doses, such as one or two tablets of the oral sulfonylureas, may produce profound and persistent hypoglycemia that may last for days and may require the continued use

of hypertonic glucose solutions to maintain life. Some of these patients either have died or have had permanent neuropsychiatric difficulties. This has been reported primarily with tolbutamide. The probable mechanism is inability to carboxylate tolbutamide.

Tolbutamide is largely excreted in the urine as the carboxylic acid metabolite produced by oxidation of the methyl ring. It is of interest, therefore, that there has been demonstrated an apparent inability to either form or excrete the carboxyl tolbutamide metabolite, ie, an apparent inability to metabolize and excrete tolbutamide, resulting in high therapeutic levels long after discontinuation of the drug. This suggests a metabolic (enzymatic) defect. In keeping with this theory, a patient has been observed with a prolonged tolbutamide-induced hypoglycemia, with a persistently high serum level after discontinuation of the medication. Another way of saying this is that the patient does not have the ability to inactivate the drug.[2, 3] A similar case with the use of acetohexamide (Dymelor) has recently been observed.

Soon after the sulfonylureas were introduced, they were advocated for many nondiabetic conditions, including acne, angina, parkinsonism, multiple sclerosis, thromboangiitis obliterans, and arteriosclerosis. The hypoglycemic effects of sulfonylureas in nondiabetics is much more marked than in the diabetic; severe hypoglycemic reactions may, and indeed did, develop even with small doses in nondiabetic patients, particularly the elderly or debilitated individuals, and are followed by serious, irreversible effects.

Fajans[4] reported that the intravenous administration of sodium tolbutamide to six patients with functioning islet cell adenoma produced profound decrease in blood sugar concentration for a prolonged period. There is a twofold importance to this: if one suspects the presence of an islet cell adenoma and is performing the intravenous tolbutamide test for diagnostic purposes, he should be thoroughly prepared to administer large amounts of glucose intravenously for prolonged periods of time. On the other hand, it must be appreciated that this can be an important and definitive diagnostic procedure.

In a discussion of hypoglycemia as a side effect and complication, it must be borne in mind that the combination of sulfonylurea drugs with phenformin is a potent hypoglycemic agent and may at times cause profound hypoglycemia.

Side Effects

Side effects of any of the drugs may be divided into hypersensitivity reactions and those which are dose related. In general, those which are dose related are readily controlled by either reducing the quantity or stopping the drug. Hypersensitivity reactions almost always occur during the first few weeks of therapy. I recall that when the oral hypoglycemic agents were first introduced, it was feared that if they had to be discontinued and the patient again put on insulin, this would be the basis for the occurrence of severe insulin allergy insofar as interrupted therapy is often the forerunner of insulin allergy. Fortunately, this eventuality has not come about, and I have never seen a case of insulin allergy when insulin has had to be reintroduced under these circumstances.

One of the more important hypersensitivity reactions is jaundice. Jaundice when it occurs with the oral agents is invariably the hypersensitive type, namely, cholestatic hepatitis. These cases, fortunately, have all been relatively mild and the patients have recovered when the drug was discontinued. Hepatitis was formerly much more common with chlorpropamide; however, since the recommended dose of chlorpropamide has been reduced to a maximum of 500 mg, there have been virtually no cases of clinical jaundice. The incidence of hepatitis today with any of the sulfonylureas is minimal in frequency and mild in nature.

Another hypersensitivity reaction is that following the ingestion of alcohol. In a few patients who are taking sulfonylurea drugs, the ingestion of alcohol results in redness and flushing of the skin (the color has been described as "cerise"). Other than the discomfort and embarrassment of the acute color change, this has no significance. Rarely, with chlorpropamide, the ingestion of alcohol may produce a severe disulfiram (Antabuse) reaction. Also among the hypersensitive reactions are the dermatologic complications, including erythema nodosum, maculopapular rashes, and, rarely, exfoliative dermatitis.

Although mild and usually transitory, changes may occur in liver function tests. A prolonged study by Haunz[5] of liver function in patients treated with chlorpropamide revealed that after

five years there was no significant elevation of SGOT, SGPT, or alkaline phosphatase levels. When changes in liver function do occur, they are those of an inconstant and usually temporary increase in serum alkaline phosphatase and sulfobromophthalein retention.

The nonallergic toxic reactions have been classified as hematologic or gastrointestinal in nature. Occasionally, interruption or even discontinuation of therapy is indicated. The most frequent side effects with the sulfonylureas in the gastrointestinal tract are anorexia, nausea, vomiting, epigastric discomfort, and, rarely, diarrhea; these are infrequent and usually mild.[6] Many of the gastrointestinal symptoms associated with these drugs have been eliminated by simply omitting coffee from the diet.

Agranulocytosis has been reported in three cases with chlorpropamide and one case with tolbutamide. Further investigation showed that in at least one case the platelet agglutination test result was positive, thus supporting the concept of there being an immunologic mechanism. One fatal case of aplastic anemia while the patient was receiving tolbutamide has been reported, but the relationship is highly questionable.

Other described side effects include chest pain and muscle weakness. One case of nephrosis has been reported during tolbutamide administration, but it has only a presumptive relationship. More recently, an association between these drugs and the induction of hypothyroidism has been suggested; this must await further confirmation.

Biguanides

Since the only biguanide marketed in this country is phenformin, I shall use the latter name. This drug may produce the side effects of nausea, vomiting, anorexia, a metallic taste, and unexplained weakness and lassitude. These symptoms may be severe and definitely limit the use of this drug. The symptoms are strictly dose related, and their incidence rises rapidly when more than 150 mg/day are administered to patients.

I rarely prescribe more than 100 mg/day in any patient.

Nevertheless, since the introduction of the prolonged action form of phenformin, the incidence of side reactions has been reduced. No cases of liver toxicity have ever been reported with this drug, nor have there been any evidences of renal or hematologic abnormalities in patients taking them.

The mechanism of action of phenformin is entirely different from that of the sulfonylureas. Thus, phenformin may be used in cases where there is no functioning pancreatic islet cell tissue. This is why it was originally introduced for the treatment of the juvenile diabetic; but even in those cases where it did control the hyperglycemia and glycosuria, a stunting of growth resulted, presumably secondary to anorexia and diminished caloric intake.

The mechanism of action of phenformin revolves around its ability to inhibit some of the oxidative systems, such as cytochrome oxidase and succinic dehydrogenase.[7] This produces a state of tissue anoxia accompanied by an increase in glucose uptake and a decrease in hepatic production of glucose. The inhibition of respiration causes an increase in both anaerobic glycolysis and lactic acid production. Therefore, pyruvate and lactate may, theoretically at least, accumulate in the blood.

It also raises the serious question as to what role phenformin plays in lactic acidosis. The association of phenformin with inhibition of oxidative systems and theoretic rise in blood lactic acid with lactic acidosis seems obvious. However, more careful study and contemplation reveal: (1) lactic acidosis does not occur only in the diabetic: (2) when it does occur in a diabetic, it need not be associated with the use of phenformin; and (3) when lactic acidosis does occur, it almost invariably has an underlying severe pathologic derangement associated with shock or a shock-like state, such as severe vascular insult to the body physiology.

In a case report of attempted suicide with phenformin, there was severe abdominal pain and severe cramps, nausea, and explosive vomiting, but the blood lactate and blood carbon dioxide levels remained normal, and there was no ketonemia. Incidentally, there also was no hypoglycemia.

A special committee appointed by the American Medical Association concluded that phenformin does not play a role in lactic acidosis coma when it occurs in diabetes. Nevertheless, when one has a diabetic patient taking phenformin and the patient develops any symptoms that could possibly be an

underlying cause of lactic acidosis, it would seem logical to discontinue the drug.

It is important to note that phenformin seldom if ever lowers the blood sugar into the range of significant hypoglycemia.

General Comments

All these drugs share one factor in common, namely, they are usually inadequate to control the diabetes under conditions of stress, including major surgery, trauma, vascular insults, and severe infection. Under such circumstances, they should be discontinued and insulin used until the acute distress has been controlled; they then may be reinstituted.

Certainly it seems clear that it should be first established whether dietary therapy is inadequate to control the diabetes before using any of these drugs. The role of gross dietary indiscretion in promoting therapeutic failure is considerable. Because drug treatment is so convenient, some patients become careless about their diet. In actuality, the diet requires as great attention as with insulin. Diet control is clearly allied to success with the oral agents.

Although we have been discussing the complications associated with the use of oral agents, a very serious question arises as to the effect of these drugs on diabetic complications per se, specifically the microangiopathy and neuropathy. When first introduced, it was hoped that these drugs would not only help control the carbohydrate metabolic abnormality, but also would have a salutary effect on the degenerative aspects of the disease. It may be categorically stated at this time that the drugs have had no beneficial effect whatosever on complications. Conversely, however, the drugs have had no deleterious or adverse effects on the basic complications. Occasionally one sees acute diabetic neuritis precipitated after control of the diabetes has been established with one of these drugs. It is important, therefore, to realize that the drug is not the offending agent. Rather, it is the sudden institution of control, and not the therapeutic agent, be it insulin, diet, or oral hypoglycemic agent.[8]

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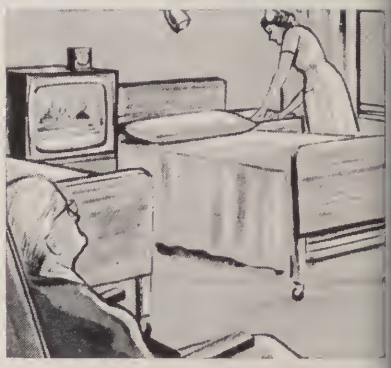
Phenformin hydrochloride—*DBI*

Tolbutamide—*Orinase*

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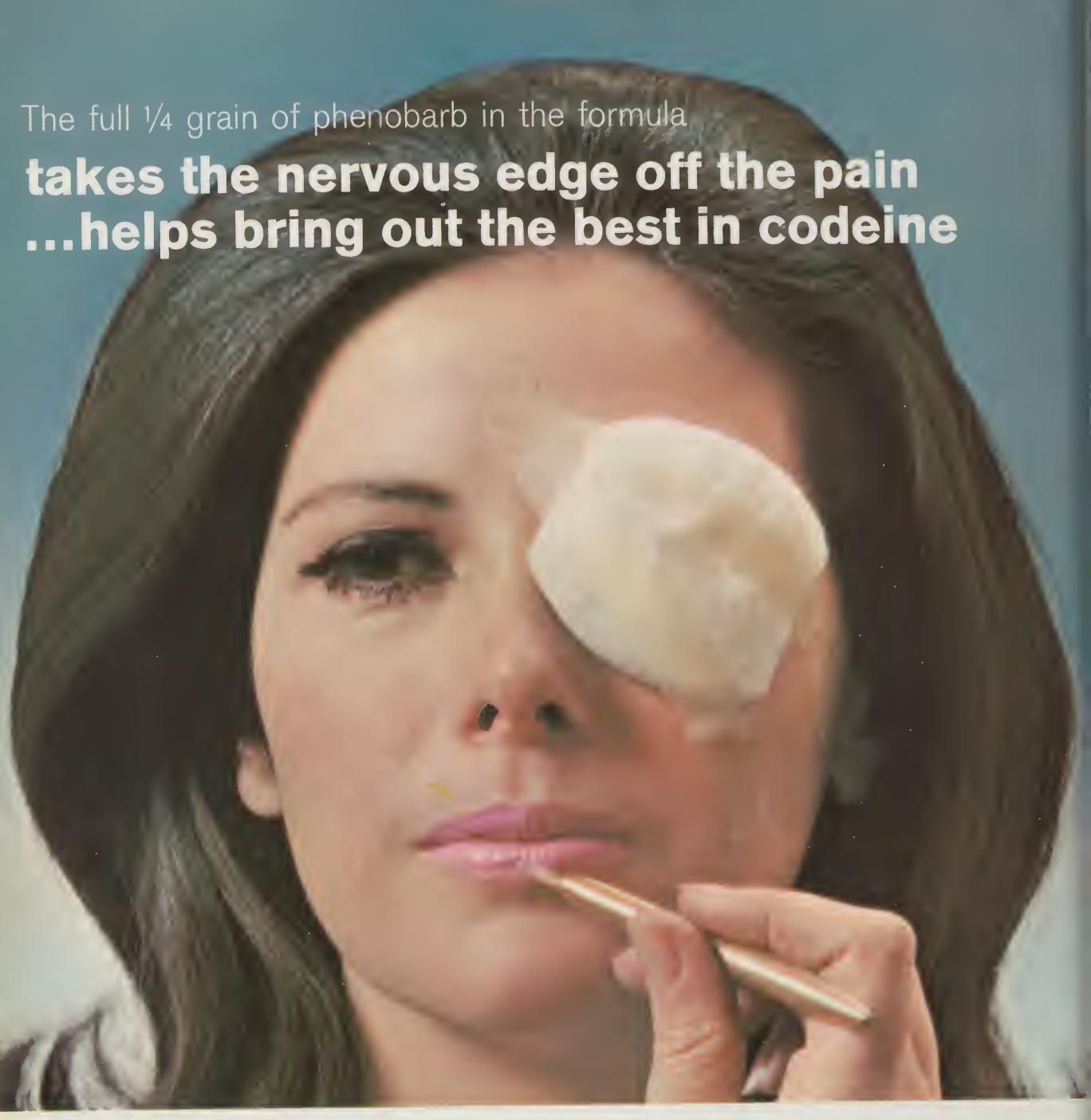
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ACUTE AND CHRONIC INFLAMMATION OF THE BRONCHIAL TREE

WILLIAM KEITH C. MORGAN, MD
Assistant Professor of Medicine
University of Maryland School of Medicine

To some extent every patient with pneumonia, no matter whether bacterial, rickettsial, viral, or chemical in origin, has some concomitant bronchitis and tracheitis. In general, the symptoms produced by the bronchitis are of minor severity and as the pneumonia responds to treatment, they subside. Rarely cough may be so irritative and distressing, as for example in primary atypical pneumonia, that symptomatic treatment is necessary. If this is so, then the best agents for suppressing cough are either codeine or dextromethorphan. In some instances relief can be obtained by providing adequate humidification of the patient's room. This can be done effectively with a simple type of humidifier such as is used in the treatment of infantile broncholitis and which is available for rent from many pharmacies. These forms of bronchitis are of importance only as manifestations of the original disease and further discussion of them is not indicated.

In any discussion of chronic inflammation of the bronchial tree, the two diseases that immediately spring to mind are chronic bronchitis and bronchiectasis. The latter is becoming relatively uncommon and, moreover, as its management is well-described in most textbooks, it is felt that it would be superfluous to give a long and detailed description of the disease in this paper. It seems more appropriate to say something about the less well-known but much more common condition of chronic bronchitis. This entity is being recognized with increasing frequency now; 20 years ago, however, a diagnosis of chronic bronchitis was meaningless to most physicians in the United States. Currently, the disease has acquired a certain notoriety as a cause of considerable mortality and morbidity in England and to a lesser extent in the United States and Western Europe. Increased interest in the condition and the more adequate dissemination of medical knowledge have led to its being described, if a trifle sparsely, in the recent editions of the standard textbooks of medicine used in the United States. Prior to this it had been known as "smoker's cough," a term which sounds so innocuous that it was not thought worthy of mention in learned texts.

Chronic bronchitis is defined as a disease characterized by the secretion of excess mucus by the bronchial tree. Pathologically there is an increase in the number of mucous glands and goblet cells present in the bronchial wall. This was first demonstrated by Dr. Lynne Reid[1] and is illustrated in the Figure*. In a normal person the mean depth of the mucous gland layer (A) is less than 25% of the distance from the epithelial surface of the bronchial mucosa to the cartilage (B). In a person with bronchitis the ratio A/B may be 50%

Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 21, 1966.

*Page 58

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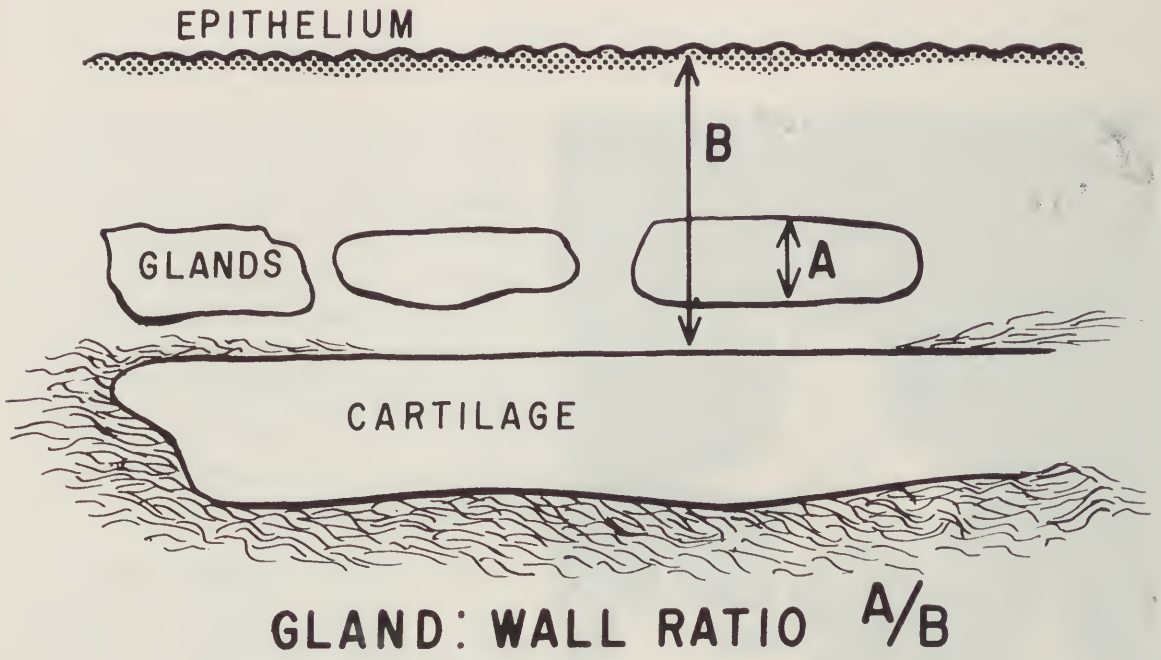
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or more. With the cessation of smoking, the mucous gland hypertrophy and bronchial wall changes revert in part towards normality.

Clinically, chronic bronchitis manifests itself by symptoms of cough and sputum which occur in the absence of localized destructive disease of the lungs such as bronchiectasis or tuberculosis. A normal person secretes about 100 ml of mucus per day. This is analogous to insensible perspiration in that one is not aware of it as it is continuously swept up by ciliary action and subconsciously swallowed. By the time chronic bronchitis has developed, the subject usually has a persistent cough. At first the cough is often relatively dry, but as time goes on, it produces increasing amounts of mucoid sputum. The disease characteristically affects male cigarette smokers living in urban communities. In the early stages, the symptoms of cough and sputum are accepted with equanimity as the price which the smoker must pay for his pleasure. Later his attitude changes and he finds the price exorbitant. After 5 to 10 years of his smoker's cough, the patient notices that every time he has a viral infection of his upper respiratory tract, it tends "to go to his chest." His sputum becomes mucopurulent or frankly purulent, and there is concomitant shortness of breath. He is now suffering from obstructive airway disease, and clinical signs of emphysema are occasionally found. From now on his course is that of slow but steady deterioration until he finally succumbs to cor pulmonale or respiratory failure.

Assuming the subject with chronic bronchitis seeks medical aid, what can be done to alleviate his symptoms? It seems that the excess mucus is secreted as a protective measure to counteract the chronic irritation produced by air pollution and cigarette smoking. The cessation of smoking is therefore imperative if it is hoped to arrest the progress of the disease. Secondly, one can attempt to relieve the associated obstruction of the smaller airways. In general this is irreversible and, consequently, attempts to do this are not too rewarding. A third approach concerns itself with the treatment of the infective element of the disease. Much of the morbidity and some of the mortality produced by chronic bronchitis seem to stem from the acute exacerbations that occur most frequently in the winter months. During the exacerbations, which usually last for five to ten days, the patient's cough becomes worse, his sputum changes from mucoid to mucopurulent or frankly purulent, he is often more short of breath, and he sometimes has minor constitutional symptoms, including anorexia and occasionally low-grade



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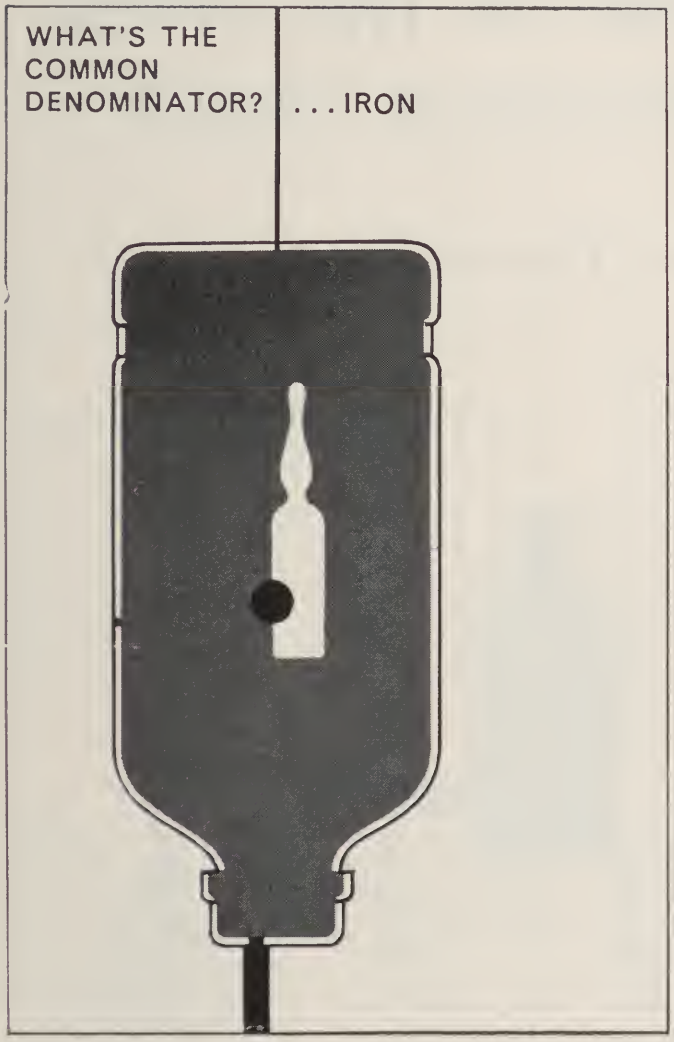
fever. The precipitating factors and exact cause of these exacerbations are still not fully understood, but recently considerable progress has been made towards this end. During remissions when the patient's sputum is mucoid, cultures yield a variety of organisms, including *Diplococcus pneumoniae, Haemophilus influenzae, Neisseria catarrhalis,* and various streptococci. Many of these bacteria seem to be present in the mouth and nasopharynx as commensals only. In contrast at the time of the exacerbations when the sputum is purulent, *D pneumoniae* and *H influenzae* are isolated much more frequently and it seems that the purulence of the sputum is directly related to the number of these two organisms present.[2] Furthermore, suitable antibiotic therapy reduces not only the purulence of the sputum but also the frequency of isolation of both *H influenzae* and *D pneumoniae.* It has also been possible to demonstrate an increased incidence of antibodies to *H influenzae* in subjects with chronic obstructive airway disease; however, no rise in antibody titer was found at the time of the exacerbations or immediately following them.[3] Thus, there is good circumstantial evidence that *D pneumoniae* and *H influenzae* play some role in either the development or prolongation of the exacerbations. Additional evidence in favor of this hypothesis can be found from bacteriological examination of the secretions of the lower respiratory tract. If during bronchoscopy the bronchial tree of a normal subject is washed out with a saline solution and the aspirate cultured, it will be found to be sterile. In contrast, if the same procedure is carried out in a patient with chronic bronchitis, the culture of the aspirate usually yields *H influenzae* and *D pneumoniae.* The presence of these organisms in the lower respiratory does not of necessity incriminate them as pathogens, but taken in conjunction with the other evidence already outlined, it is possible to build up a pretty good case against them. On the other hand, were bacterial infection the whole story, it should be possible to prevent the acute exacerbations by putting susceptible subjects on a suitable antibiotic throughout the winter months. This desired state cannot be realized for although, daily administration of tetracycline throughout the winter lessens the duration of the exacerbations and also seems to prevent or reduce the severity of some of them, complete protection cannot be achieved by this means.[4] Therefore, it seems that factors other than primary bacterial infection of this disease precipitate the acute exacerbations. Carilli and his co-workers studied the natural course of this disease and showed that an antecedent viral infection preceded the exacerbations in about 50% of their subjects.[5] Thus, it seems that viral infections may damage the bronchial mucosa and allow secondary bacterial infection to occur. It also seems probable that air pollution can act in a similar fashion. The evidence to date suggests that the prompt and effective treatment of these exacerbations is as effective as are long-term antibiotics. It is therefore recommended that any patient with chronic bronchitis who develops an upper respiratory tract infection with an associated increase in the purulence of his sputum should immediately be given a seven-to-ten-day course of an appropriate antibiotic. In this context, one of the tetracyclines (2 gm/day) or ampicillin (2 to 4 gm/day) is to be preferred. Without any doubt, the best means of avoiding the morbidity and mortality associated with the acute exacerbations is to prevent them. To a great extent this could be effected if there were an active polyvalent vaccine available for use against the majority of the common viral pathogens affecting the respiratory tract. No such vaccine exists to date, although attempts are being made to manufacture one. Until we can prevent the exacerbations, it behooves us to make every effort to treat them as effectively and as early as possible.

University Hospital
Redwood and Greene St
Baltimore, Md 21201

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MANAGEMENT OF INFLAMMATION OF THE UPPER GASTROINTESTINAL TRACT

Part I. Acute and Chronic Pancreatitis

ROBERT A. FISCHER, MD
Clinical Instructor in Medicine
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A discussion of the management of inflammatory disease of the upper gastrointestinal tract should properly include that portion of the alimentary canal between the mouth and the ileocecal valve, as well as the pancreas, liver, and biliary tract. I would like to limit myself to a discussion of the management of one of the most common inflammatory problems, pancreatitis, and one of the less common but most interesting "inflammations," regional enteritis.

We may divide pancreatic inflammatory disease into two broad classifications,—acute and chronic pancreatitis. We will later point out that a further subclassification is necessary in any discussion of chronic pancreatitis.

Acute pancreatitis may cover a spectrum of inflammation ranging from relatively mild pancreatic edema, (ie, seen with mumps parotitis) to severe, fulminating, largely fatal, necrotic pancreatitis. Since therapy of the former is relatively simple and the outcome uniformly good, I should like to discuss that form of pancreatitis which we label acute necrosis of the pancreas and which includes all instances of acute, necrotic, severe pancreatitis. In this form, hemorrhage may or may not be a prominent feature. Suppuration is relatively infrequent.

Though the purpose of this symposium is not to discuss the etiology and pathogenesis of acute pancreatitis, it should be remembered that the overwhelming majority of cases are associated with either alcoholism or biliary tract disease. It is important to distinguish between these two etiologies because the therapy and prognosis may differ.

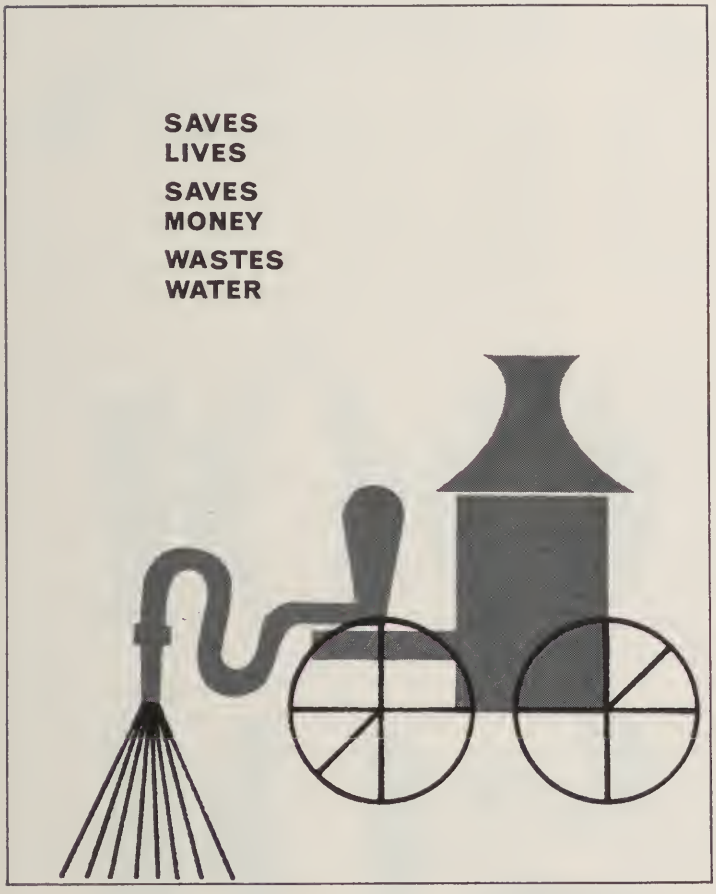
Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 21, 1966.

MEDICAL THERAPY OF ACUTE PANCREATITIS

Not too many years ago, surgery was felt to be the treatment of choice in acute pancreatitis. This consisted mainly of cholecystectomy and lesser sac drainage. Mortality was, however in excess of 50%. At present, gastroenterologists and surgeons mostly agree that it is unwise to attack acute pancreatitis surgically except when suppuration or a developing mass has occurred. The other indication for emergency surgery is the necessity of ruling out a possibly perforated viscus. Conservative medical management is today the treatment of choice for acute pancreatitis, and may be divided into control of the following modalities.

A Shock, Dehydration, and Electrolyte balance. —The most urgent requirement is the prevention and/or treatment of shock. The patient with an

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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

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acute necrotic pancreatitis may lose large amounts of whole blood. Initially, plasma loss may be extremely severe with a subsequent later fall in red cell masses. We have found it expedient to use either plasma, albumin, or whole blood replacement. One must never underestimate the immense capacity for volume loss in acute pancreatitis. With the relatively simple methods today of measuring central venous pressure in the right atrium, vigorous fluid replacement therapy can be undertaken without fear of circulatory overloading. Low molecular weight dextran has been found useful in emergency situations where plasma or whole blood are not available.

Constant gastric suction must be employed to remove the stimulus for continuous pancreatic secretion. Because of this, electrolyte replacement must be given intravenously on the basis of daily requirements and loss through continuous suction. One must keep an adequate urinary output, maintaining at least 1000 cc of urine a day if possible. The onset of renal failure is a very poor prognostic sign and makes the management of electrolyte balance even more difficult.

Saponification of peripancreatic and mesenteric fat may cause removal of massive amounts of calcium from the circulation. This may become apparent, especially on the second or third day of illness. A concentration of less than 7.5 mg/100 ml is associated with a greater than 80% patient mortality. Calcium losses may necessitate the use of amounts of intravenous calcium. We have found that a 10% solution of calcium gluconate-glucoheptonate is satisfactory for replacement therapy. The presence of a persistently normal serum calcium level in the face of a severe acute necrotic or hemorrhagic pancreatitis should alert one to the possibility of a functioning parathyroid adenoma. Reports of hyperparathyrodism in association with acute pancreatitis have been increasing in recent years.

B. Control of Pain.—It is important to appreciate the necessity for relieving the pain of acute pancreatitis, since it may cause severe vasoconstriction, leading to decreased blood flow to the myocardium, and may so impair pancreatic blood flow as to convert pancreatic edema into necrosis. Meperidine (Demerol) in doses of 50 to 100 mg administered intramuscularly every 3-4 hours, appears to be the best choice. In addition to its atropine-like action, it causes less sphincter (Oddi) and duodenal spasm than morphine. This advantage may be lost, however, with increasing doses of meperidine. It has been used in combination with papaverine (2 gm, given intravenously) or nitroglycerin ($\frac{1}{100}$ – $\frac{1}{150}$ grains) to enhance the analgesic effect by reducing spasm. In patients who do not respond to meperidine, a 1% solution of procaine (20 ml), slowly given intravenously, may be of help. One must be alert to the possibilities of hypersensitivity and anaphylaxis when using this drug. Where pain continues, one may try an epidural block which provides bilateral anesthesia and anesthetizes both the cerebrospinal and afferent visceral fibers which come from the pancreas.

C. Suppression of the Pancreatic Secretion.—Basic to the successful treatment of acute pancreatitis is the suppression of the pancreatic exocrine secretion by curtailing the secretin mechanism. This is accomplished with (a) continuous gastric suction (with the possible exception of small amounts of antacid when the patient is able to take oral feedings), and (b) suppression of cholinergic stimulation with anticholinergic drugs. It has been our experience that methantheline (Banthine), 50 mg given intramuscularly every four to six hours; propantheline (Pro-Banthine), 15 mg given intramuscularly every six hours; atropine sulfate, 0.4-0.8 mg given every four hours intramuscularly; or tridihexethyl (Pathilon), 10-20 mg given every six hours intramuscularly, have been equally effective. Others have reported more potent inhibition of pancreas secretion with drugs such as pipenzolate (Piptal) and mepenzolate (Cantil) in doses of 5 to 25 mg given intramuscularly every six hours, respectively. The carbonic anhydrase inhibitor, acetazolamide (Diamox), has been used in doses of 250-750 mg/day in an effort to reduce the volume and bicarbonate concentration of pancreatic secretion.

D. Antienzyme Preparations.—Recently, antienzyme treatment preparations have enjoyed usage, especially in Europe. The criteria for the usage has been based on the idea that some of the deleterious effects of acute pancreatitis are due to the activation of pancreatic proteolytic enzymes and to the elaboration of biological reactive polypeptides, similar to bradykinin. It is proposed

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Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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that in acute pancreatitis trypsin stimulates the conversion of bradykiningen to bradykinin. It is this active principle which is responsible for local pain, vasodilatation, increased vascular permeability (leading to severe loss of fluid into the peritoneal cavity), hypotension, smooth muscle stimulation and the inflammatory reaction. The most popular and recent of these antienzyme preparations is Trasylol or Trasylol-Bayer A-128,* an antienzyme developed in Germany and demonstrated experimentally effective against the production of trypsin, kallikrien, chymotrypsin, and fibrinolysin. The initial enthusiasts reported mortality reduced considerably in acute necrotic pancreatitis when Trasylol was given intravenously. However, further studies in both the United States and Europe have been discouraging and report little change in mortality or morbidity. Recent laboratory experiments revealed that to be at all effective Trasylol must be given early in the course of the disease and in very large doses, exceeding 100,000 units daily. For this reason it may be effective in cases of acute pancreatitis found following surgery, in the patient who is already hospitalized.

E. Infection.—The role of infection in pancreatitis has been difficult to evaluate. It is not considered a common cause and for this reason the role of antibiotics in acute pancreatitis is uncertain. We have employed antibiotics (penicillin, streptomycin, the broad spectrum tetracyclines and, recently, sodium cephalothin [Keflin]) only in fulminating illness where there is evidence of superimposed infection, peritonitis, suppuration, and/or abscess formation. Under these conditions we feel that large doses are indicated.

F. Carbohydrate Metabolism.—Transient diabetes mellitus may be seen in 50% of cases of acute pancreatitis. This is usually transient in nature, but may less commonly proceed to diabetic acidosis. For this reason it has been recommended that 10 units of regular insulin be given with each 50 gm of glucose administered in 1,000 cc of water. Except in cases of shock we have preferred to give regular insulin subcutaneously every four to six hours on the basis of fractional urine coverage. It must be remembered that diabetic coma is rare in pancreatitis, but represents a catastrophic, almost uniformly fatal, event.

G. Steroid Therapy.—Although there have been isolated reports of increased survival rates following the administration of adrenocortical steroids in severe, acute pancreatitis, most investigators have been hesitant to use them. Steroids have been shown experimentally, and in humans, to cause pancreatic damage and to increase both pancreatic enzymes and biocarbonate concentration in early phases. For this reason we feel that steroids should be used only, if at all, in the acute stage of fulminating pancreatitis with vascular collapse.

H. Hypothermia.—Recent experiments have revealed an increased survival rate in dogs with acute hemorrhagic pancreatitis with generalized hypothermia. Others have reported increased pancreatic damage and enzyme secretion, secondary to cooling. We have not been impressed with the results seen in the few cases in which hypothermia has been employed in acute pancreatitis.

SURGICAL THERAPY OF ACUTE PANCREATITIS

As stated earlier, immediate surgical intervention is rarely indicated in acute pancreatitis. Certainly, no operation should be contemplated until the patient's cardiovascular system has been stabilized. With this in mind, emergency surgery may be undertaken: (a) only if such catastrophies as peritonitis, perforation, bowel obstruction, or vascular occlusion cannot be ruled out; (b) where there is clinical and laboratory evidence of abscess or pseudocyst formation (This may be extremely difficult and diagnosis can only be made with evaluation of the full clinical and x-ray picture); or (c) where jaundice fails to recede in an otherwise clinically improving patient. In the event surgery is performed and cholelithiasis is found, a cholecystectomy may be performed in the presence of mild pancreatic edema. The presence of an acute necrotic pancreatitis calls for a cholecystostomy with cholecystectomy deferred until the patient has recovered from his pancreatitis.

Although we have confined our remarks to the treatment of the acute pancreatitis itself, it should be mentioned that there are various complications of this illness which may require treatment. Among them are renal failure, massive ascites,

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splenic rupture, hepatic necrosis and congestion, and focal myocardial necrosis.

The duration of the intensive regimen described above should be determined by the clinical state of the patient. In the vast majority of patients who will recover from their illness, the convalescent stage is usually entered into in approximately five to seven days. Failure to respond in this period of time denotes a poor prognosis.

THERAPY FOR CHRONIC PANCREATITIS

Pancreatitis may be classified in the following way.

A. 1. Acute pancreatitis.
   2. Relapsing acute pancreatitis (pancreatic restitution takes place following the illness).

B. 1. Chronic pancreatitis.
   2. Chronic relapsing pancreatitis (residual pancreatic damage remains even though the patient may recover from recurrent episodes of acute inflammation).

MEDICAL THERAPY OF CHRONIC PANCREATITIS

The episodes of acute and chronic relapse in chronic pancreatitis are treated the same way initially as discussed previously for the acute pancreatitis with recovery. In the period of silence or remission following the acute exacerbation, efforts should be made to prevent additional seizures and further pancreatic damage. This should include: (a) a bland, relatively low fat and low roughage diet with avoidance of secretory stimulants to reduce gastric acid and secretion stimulation and (b) the avoidance of alcohol in patients with alcoholic pancreatitis.

There is no reliable evidence that the use of alcohol by patients with pancreatitis, secondary to biliary tract disease, enhances damage. However, we have impressed upon this type of patient the necessity for extreme moderation. Certainly, in those patients with alcoholic pancreatitis, all effort should be made to eliminate the use of alcohol.

In the presence of unmistakable pancreatic insufficiency, ie, steatorrhea, malabsorption, and diabetes mellitus, therapy must also be aimed at controlling these disturbances. We must preface all remarks, by saying that the medical as well as the surgical treatment of chronic pancreatitis and pancreatic insufficiency represents at this time a tremendous challenge to the physician. It is often extremely frustrating and, worse, only partially successful.

The dietary restrictions as described above, must be modified to compensate for the nitrogen loss in the stools. We believe that a diet containing 150 gm of protein per day should be taken. Dietary fats should be limited to approximately 50 gm or less per day. Because of the poor hydrolysis in pancreatic insufficiency, the presence of dietary fat in large amounts tends to increase diarrhea.

Pancreatic enzyme substances in the form of nonenteric-coated viokase (0.5-1 gm) and triple strength pancreatin (2-5 gm) should be employed when there is evidence of steatorrhea. Because of the mechanics of digestion, these enzymes should be given every hour while awake for best results. One may add bile salts to the regimen to assist in fat digestion. There may be a deficiency of the fat-soluble vitamins A, D, E, and K. These may be administered in water-soluble preparations, to be taken orally or parenterally if necessary. Calcium supplementation in the form of large oral doses of calcium gluconate (6-12 gm daily) may also be necessary.

Iron deficiency anemias are uncommon in chronic pancreatitis except following an acute attack. Indeed, iron absorption appears to be increased in chronic and calcific pancreatitis. The use of pancreatic enzyme derivatives actually decreases the absorption rate. However, in the late stages of the illness, severe steatorrhea may be associated with a deficiency in iron absorption. In these cases parenteral iron supplements such as iron dextran injection (Imferon) should be used. After an initial loading, calculated on the basis of the patient's weight and deficit, one may give additional increments of 4 cc intramuscularly every six months.

Recent investigations have revealed that exocrine pancreatic function is essential for the normal absorption of vitamin B_{12} and folic acid. For this reason it may be necessary to supplement the diet in chronic pancreatitis with folic acid, 5-15 mg/day, followed by 5 mg/day, and cyanocobalamin, 30 mg administered intramuscularly on a monthly basis.

Perhaps the most difficult aspect of the management of chronic pancreatitis is that of control



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of pain. It may become extremely difficult to evaluate the psychophysiological aspect of pain in chronic pancreatitis. Its very chronicity makes it one of the most demoralizing forms of discomfort. The keystone of analgesic therapy is the avoidance of the use of opiates since these patients are extremely susceptible to addiction. Tranquilizers (ie, chlordiazepoxide [Librium], meprobamate [Equanil, Miltown], diazepam [Valium], etc), barbiturates, and anticholinergics should be tried initially. All of the nonopiate analgesics should be employed, although there is relatively little likelihood of their success. We have found the combination of phenothiazine derivatives, such as promazine (Sparine), 50 mg t.i.d., promethazine (Phenergan), 25 mg t.i.d., and perphenazine (Trilafon), helpful in enhancing the effect of various analgesics. When the need for a narcotic eventually arises, we have used a mixture of oxycodone hydrochloride, oxycodone terephthalate, homatropine terephthalate, aspirin, phenacetin, and caffeine (Percodan) or codeine first in conjunction with the above mentioned drugs because they are less likely to cause addiction. We have found that a patient and understanding, but firm clinical approach is much more successful in handling the emotional trauma of this disease than is formal psychiatric therapy.

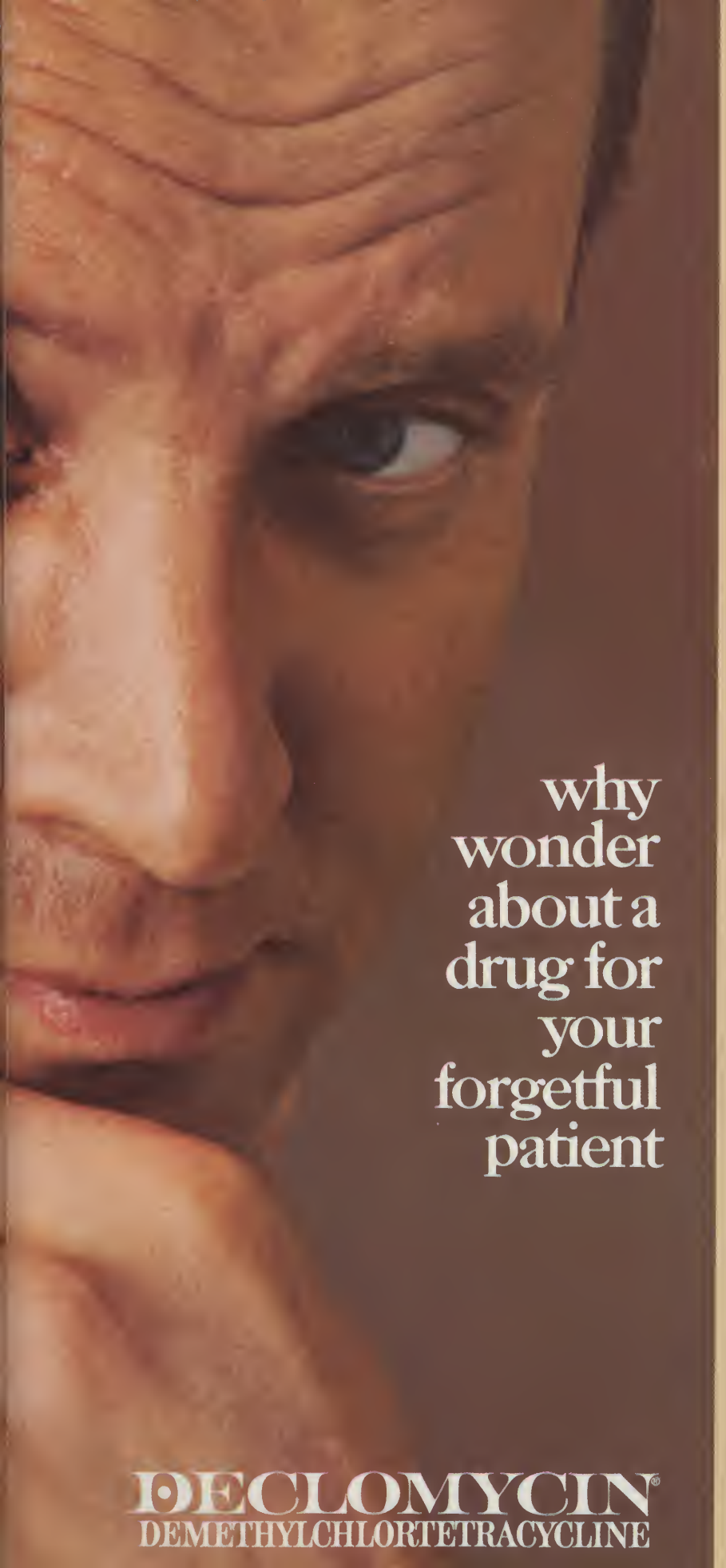
SURGICAL THERAPY OF CHRONIC PANCREATITIS

The surgical approach to chronic pancreatitis has also been something less than successful. The great variety of procedures advocated attest to the lack of uniform success with any one or group of procedures. The type of surgical approach is dictated by the problem. In general, the following are reasons for surgical intervention in chronic pancreatitis: (a) development of pancreatic pseudocyst or peripancreatic abscess, (b) relief of intractable pain, unrelieved by conservative measures, (c) continuing jaundice and/or biliary tract disease, (d) evidence of mechanical obstruction to the outflow of pancreatic juice to account for recurrent attacks and (e) the possibility of pancreatic carcinoma. It is not the purpose of this paper to give a discourse on the surgical management of the problems of chronic pancreatitis, but since it is usually the medical physician who is called on to initiate surgical consultation, a knowledge of the procedures available is important.

The complications of pancreatic pseudocyst were originally handled through external drainage in the poor-risk patient, but recently, internal drainage via a cystogastrostomy or cystjejunostomy has proved more successful, especially in avoiding chronic external fistula formations. Many surgeons advocate sphincterotomy be performed at this time.

If there is suspicion of biliary disease, exploration of the choledochal-sphincteric area is essential. The patient should undergo preoperative intravenous cholangiogram while on the operating table. In those cases where blockage of the ampulla is indicated and demonstrated by failure to pass a 3-5 mm sound easily through it, sphincterotomy is indicated. The pancreatic duct should then be cannulated and a sample of pancreatic juice taken. If there is any doubt as to the patency of the duct, a retrograde pancreatogram should be made. If there are no serious abnormalities of the pancreatic duct, the transduodenal sphincterotomy may be successful in relieving symptoms in 50% of cases. If a single or few

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Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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large calculi are found within the pancreatic duct, a pancreaticolithotomy may relieve obstruction. More commonly, however, multiple sites of obstruction are present. This may necessitate a partial pancreatic resection of the distal pancreas with pancreaticojejunostomy providing drainage of the pancreatic duct into the jejunum. Choledochojejunostomy with Roux-Y procedure may be used when there is concomitant common duct obstruction. The procedure of pancreaticoduodenectomy is a difficult one and has been used mainly where there is overwhelming destruction of the pancreas and intractable symptoms. Those patients who do survive the procedure present extremely difficult medical management problems with respect to their nutrition and diabetes mellitus. We feel that this procedure is rarely indicated.

Finally, the least successful of all pancreatic surgery is that which is specifically directed toward relieving intractable pain. A variety of procedures including thoracolumbar sympathectomy, splanchnicectomy, vagotomy, and celiac ganglionectomy have been performed. By and large results have been poor. One must remember that in advanced pancreatitis the cerebrospinal nerve endings also transmit pain impulses from the pancreas.

There are few diseases which call for more skill on the part of the clinician than does chronic pancreatitis. With or without surgical intervention, the results are rarely successful.

GENERIC AND TRADE NAMES OF DRUGS

Acetazolamide—*Diamox*
Chlordiazepoxide hydrochloride—*Librium*
Dextran—*Dextran, Gentran*
Diazepam—*Valium*
Iron dextran injection—*Imferon*
Mepenzolate bromide—*Cantil*
Meperidine—*Demerol*
Meprobamate—*Equanil, Miltown*
Methantheline—*Banthine*
Perphenazine—*Trilafon*
Pipenzolate—*Piptal*
Promazine—*Sparine*
Promethazine—*Phenergan*
Propantheline—*Pro-Banthine*
Sodium cephalothin—*Keflin*
Tridihexethyl—*Pathilon*

Part II. Regional Enteritis

Regional enteritis may be defined as a slowly progressive, chronic, nonspecific, inflammatory illness without known cause. It may involve the alimentary tract from the stomach to the ileocecal valve. Indeed, pathologic changes in the colon are being described with increasing frequency. While the overall mortality of regional enteritis is quite low (2%), it presents difficult problems in management for the clinician because of the disability that it can produce. This is compounded by the uncertainty among many physicians as to what can be accomplished and what are realistic goals for the patient with regional enteritis.

MEDICAL MANAGEMENT

The treatment of regional enteritis is essentially medical, although a majority of patients will eventually come to surgery. Of the 542 patients with regional enteritis, followed in the Mount Sinai Hospital series, nearly 80% eventually underwent surgical intervention. The acute phase of ileitis may often be mistaken for appendicitis and may come to surgery. If during the operation the cecum and appendix are found to be uninvolved, it may be prudent to proceed with an appendectomy, thus removing a future source of difficulty in differential diagnosis. However, if the inflammatory process is severe, with mesenteric thickening and involvement over the cecum or the appendix, the operation should be terminated without corrective surgery.

We may divide the medical therapy of enteritis into the broad categories of general and specific therapeutic measures.

A. General Therapeutic Measures.—Physical rest is one of the most effective and necessary aspects of medical treatment. It may require bed rest with bathroom privileges initially, and restricted physical activity for weeks or months. Certainly, in the acute stages of the illness, the physician should be guided by temperature, relief of pain, cramping and diarrhea, weight improvement, correction of anemia, electrolyte and protein balance, and white blood cell counts in regulating

out-of-bed activity. We have found that relief of the acute symptoms can be rarely accomplished in less than 10-14 days. Along with physical rest, emotional rest is vitally important. Relief from worry, tension, and pressing responsibilities helps greatly in speeding recovery. We have found the barbiturates (phenobarbital, 30 mg t.i.d.) or tranquilizing drugs in moderate doses to be effective. Less often, the antidepressives or phenothiazine derivatives (trifluoperazine [Stelazine], 2 mg, once a day) have been necessary.

The control of diet is basic to the treatment of regional enteritis. It plays a most important role in relieving pain and diarrhea. Above all, it must be nutritious and pleasing to the patient. Because of the protein loss, a high protein (100-120 gm) diet is indicated. Irritating high residue and gas forming foods must be avoided. This will allow most meat products. Raw fruits and vegetables (except bananas), pies, fried foods, pastry, bran, nuts, spiced foods, fermented alcoholic beverages, whole-grain wheat cereals, lentils, onion, garlic, pickles, rye crisp, lettuce, celeries, etc. sould be removed from the diet. Such gas-forming foods as legumes, cabbage, shell fish, and iced cold or very hot drinks are to be avoided. Some patients may have increased diarrhea with uncooked milk. This may be due to interference with lactose digestion and absorption, secondary to the regional enteritis. These patients will generally be able to tolerate milk products in the cooked state.

In addition to diet, there are vitamin and mineral supplements which will be needed, depending upon the area of the bowel involvement. In over 60% of patients with regional enteritis there is decreased vitamin B_{12} activity due to involvement of the terminal ileum. This may be expressed in the form of a megaloblastic anemia and usually responds well to cyanocobalamin in doses of 1,000 μg, administered intramuscularly, every three months following the initial loading dose. The restriction of fruit may well affect vitamin C levels, and it is wise to supplement the diet with ascorbic acid in doses of 100 mg three times a day. The presence of severe diarrhea may produce deficiencies in the fat-soluble vitamins A, D, E, and K. This may be remedied with the use of multivitamin tablets daily, vitamins A, D, and E, and the use of a water-soluble analog of vitamin K, such as phytonadione (Aqua Mephyton) in doses of 2.5 to 25 mg daily. Potassium (K-triplex, 5 cc t.i.d.) and calcium (calium lactate, 12 gm day in divided doses) with water-soluble vitamin D (calciferol, 50,000 units three times a day given orally) may be indicated.

In addition to the anemia associated with B_{12} deficiency, the patient with regional enteritis almost universally will present with an iron-deficiency anemia, secondary to chronic blood loss. This may be replaced with the use of various iron preparations, including ferrous sulfate and ferrous gluconate. In the event that the oral preparation cannot be tolerated, parenteral iron in the form of iron dextran injection (Imferon), replaced according to body weight and hemoglobin deficit should be given intramuscularly. The various iron preparations with enteric coated capsules may be less irritating to the gastrointestinal tract, but they are much less reliable in terms of iron absorption. When there is extensive involvement of the jejunum and duodenum, folic acid deficiency may be a problem and may necessitate parenteral and oral folic acid replacement.

Pain, especially in the form of middle and lower abdominal cramping, may be greatly relieved by the proper use of diet. In addition, the salicylate analgesics and propoxyphene hydrochloride (Darvon) may be helpful when augmented by the use of anticholinergics such as methantheline (Banthine) or propantheline (Pro-Banthine). Tincture of belladona in doses of 12-22 drops before meals has been found effective. The use of narcotics should be avoided if at all possible, although severe cramps will usually respond to moderate doses of codeine. This should be withdrawn quickly to prevent constipation.

Diarrhea, which is usually of the nonbloody type is also greatly reduced by the proper diet. In addition, the psyllium hydrophillic mucilloids (Metamucil, Konsyl, etc) in doses of 2-3 teaspoons, in fluid daily, can be quite helpful. They tend to decrease the fluidity of the stool and prevent anal and perianal irritation. In those cases requiring further therapy, denatured tincture of opium (8-15 drops every four to six hours) or diphenoxylate hydrochloride with atropine (Lomotil) in doses of 2.5 to 5 mg, four times a day may be used.

B. Specific Therapeutic Measures.—Antibiot-

ics: There is no proof that regional enteritis is caused by infection. Nevertheless, the acute disease often will respond, at least transiently, to either antibiotics or steroids. In addition, secondary bacterial invasion may be avoided. The most effective agents are the nonabsorbable sulfonamides and of these the one most frequently used is salicylazosulfapyridine (Azulfidine). This drug is apparently less successful in regional enteritis than in ulcerative colitis but may suppress the inflammatory state and prevent secondary bacterial infection. It may be given orally in doses of 1 to 1.5 gm, four times a day. Patients treated with salicylazosulfapyridine must be watched for possible blood dyscrasias or allergic reactions. Because of the high incidence of gastrointestinal intolerance, it may be necessary to switch to the less irritating sulfonamides such as succinylsulfathiazole (Sulfasuxidine) or phthalylsulfathiazole (Sulfathalidine), in doses of 1.5-2 gm, four times a day. We have found it best to keep our patients on the sulfonamides for approximately two to three months, abruptly withdrawing the drug if the patient is in remission.

Steroids: The role of adrenocortical steroids in the treatment of regional enteritis continues to be empiric. There is no real proof of permanent curative value in this illness, but one can give striking symptomatic temporary improvement. Though there is no conclusive evidence of increasing perforation with the use of adrenal steroids, one does see the usual complications with long-term use and for this reason it is to be avoided. Perhaps the greatest value of adrenal steroids is in the treatment of the extra alimentary manifestations of regional enteritis such as arthritis, uveitis, pyoderma, and erythema nodosom.

We have obtained best results in the acute phase of regional enteritis with the use of corticotropin. It may be given by intravenous drip daily in doses of 20-40 units in 1,000 cc of 5% dextrose and water over eight hours, for a period of seven to ten days. This may be followed by intramuscular injection or switching to the adrenal corticosteroids. Initial intramuscular administration of aqueous corticotropin in doses of 30 units every six hours may be used, with a gradual reduction over a period of 7-10 days to 40 units daily. We have initiated the simultaneous use of salicylazosulfapyridine in our patients. In those who have responded very rapidly, we have attempted to withhold adrenal steroids following ten days of corticotropin therapy. This has rarely been successful. In the majority of patients we have either begun with or followed corticotropin with orally administered adrenal steroids, ie, prednisone, administering orally 30 mg/day in divided doses, with gradual reduction of the dose after the first week. In order to avoid the complications of steroid usage, we have tried to withdraw them completely from our patients over a period of two to three months. However, many patients will require a longer course and/or recurrent therapy. Those patients undergoing surgery who have had adrenal steroids within the previous 9 to 12 months should receive steroids on the day prior to, and following the surgery as well as on the day of the operation. We have given 100 mg of hydrocortisone sodium succinate intramuscularly in divided doses on the day prior to and on the day of surgery. We have followed this with tapering doses over a two to three day period following surgery.

SURGICAL TREATMENT OF REGIONAL ENTERITIS

As we have stated earlier, the majority of patients with regional enteritis will require surgical intervention. Surgery is indicated for the following reasons: (a) the outright failure of medical management with continued fever, sepsis, internal fistulas, and perianal and perirectal fistulas and abscess formations, (b) intestinal obstruction, the most common cause for surgery, usually resulting from cicatricial constriction, (c) perforation, a very rare finding in enteritis, and (d) the need to establish a diagnosis. One should try to operate at a time when nutritional status is at a maximum. Surgery should not be held out as the last resort, waiting until the patient is nutritionally bankrupt. The prevailing opinion today is that resection with end-to-end anastomosis is preferable to the previously used short-circuiting procedures. If the patient is severely debilitated or has burned-out disease with acute obstruction, a lower risk bypass procedure may be indicated. Since the great majority of cases of regional enteritis involve the terminal ileum, the most common surgical procedure today is removal of the distal ileum and cecum with a cuff around the



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inflamed area, forming an ileotransverse colostomy. Unfortunately, recurrences are all too frequent, usually at the site of anastomosis. In the Columbia-Presbyterian Hospital series, there was 19% incidence of recurrence at two years, 26% at five years, and 42% at ten years. The overall recurrence rate following surgery of regional enteritis is approximately 50%. Nevertheless, excessive pessimism is not indicated since many patients will experience sustained remission for many years.

In summary, the eventual therapeutic approach to regional enteritis is most likely to be both medical and surgical. If both the physician and patient are realistic in their goals, they will be cheered by the knowledge that although this is a chronic, progressive disease, the majority of patients do experience long periods of remission and relative well-being and productivity with the help of intelligent medical and surgical care.

2400 H St, NW
Washington, D.C. 20037

GENERIC AND TRADE NAMES OF DRUGS

Diphenoxylate hydrochloride with atropine—*Lomotil*
Iron dextran injection—*Imferon*
Methantheline—*Banthine*
Phenobarbital—*Luminal*
Phthalylsulfathiazole—*Sulfathalidine*
Phytonadione—*Aqua Mephyton, Konakion, Mephyton, Mono-Kay*
Propantheline—*Pro-Banthine*
Propoxyphene hydrochloride—*Darvon*
Psyllium—*Konsyl, Metamucil*
Salicylazosulfapyridine—*Azulfadine*
Succinylsulfathiazole—*Sulfasuxidine*
Trifluoperazine—*Stelazine*



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Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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Each tablet and each 5 cc. of liquid contains:
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Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

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Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

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- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovasculor disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. 27:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

INFLAMMATORY DISEASES OF BONES AND JOINTS

JERRY C. HUNT, MD
Assistant Professor of Orthopedic Surgery
University of Maryland School of Medicine

Inflammation is a tissue reaction to injury. This reaction is characterized by increased vascularity and clinically manifested by heat, redness, swelling, and tenderness. The mechanisms of injury are varied. They all have the common factor of producing an insult to the tissues, thus eliciting an "inflammatory" response. The subsequent pathophysiology is characteristic for the particular injurious agent.

Injury eliciting an inflammatory response in bones and joints can be sustained by five distinct mechanisms.

1. *Trauma.*—In this instance trauma of an acute nature, typified by a synovitis of the knee or wrist following a severe sprain. Ligamentous sprain, pinching of the synovium, and frequently a secondary hemarthrosis invoke an inflammation of the synovium.

2. *Mechanical Stress.*—This is actually chronic trauma. There are two distinct types. The first is preceded by an alteration of anatomy from whatever cause, and the repeated trauma of one structure against another produces an inflammatory response. As an example, malunion of a fracture may leave a bony protuberance across which a tendon repeatedly glides. A bursa develops and becomes inflamed, or the tendon itself becomes inflamed. Commonly involved are the hamstring and wrist extensor tendons. Occasionally, this condition is produced by trauma to a tendon from an external source, such as the Achilles tendon against the top of a ski boot or high-top shoe, or the hamstring tendons against an improperly applied short leg cast. The second type of mechanical stress injury is better termed "attrition," by which we mean either the normal wear and tear process of daily use, such as degeneration of the rotator cuff of the shoulder, or excessive repetition of a certain motion producing a typical inflammation, such as "tennis elbow" and de Quervain's disease (of the thumb).

3. *Infection.*—Bacterial seeding of bones and joints causes a chain of injuries to the tissues manifest initially as inflammation.

4. *Neoplasia.*—Bone tumors may evoke an inflammatory response, but it is usually related to tumor necrosis. A fast growing tumor simply outgrows its blood supply, producing necrosis and an inflammatory tissue response to the necrotic material.

5. *Metabolic Bone Disease.*—These disorders may produce inflammation, but as with neoplasia, they comprise a very small percentage of inflammatory diseases. Examples are the vitamin deficiencies and excesses.

This classification is not complete. Excluded is an exhaustive list of entities unlikely to be encountered even over a period of years. My

Read before the Spring Scientific Assembly of the Maryland and District of Columbia Academies of General Practice, May 21, 1966.

purpose is to discuss commonly occurring bone and joint problems manifest by the cardinal signs of inflammation: heat, swelling, redness, and tenderness.

Bursitis and Tendinitis.—The most frequently seen inflammatory conditions are problems conveniently lumped under the general diagnosis of "bursitis." There are numerous bursae, almost everywhere a tendon crosses a bony prominence or joint. Any alteration of this smoothly gliding mechanism produces a mechanical injury to the bursa, tendon, or both. The bursal reaction to injury is swelling, tenderness, heat, and redness. The most commonly affected are the subacromial bursa of the shoulder, the olecranon bursa at the elbow, and the trochanteric bursa of the hip. History and physical examination should easily lead to the diagnosis.

The single most common inflammatory condition in orthopedics involve the shoulder. The subacromial bursa lies in the narrow space between the supraspinatus tendon and the acromion. The rotator cuff of the shoulder glides over the humeral head and under the acromion, being separated from each by the synovium of the joint and the subacromial bursa, respectively. With the arm at the side, the space between the humeral head and acromium easily accommodates the intervening structures. As the shoulder is abducted this space becomes narrowed. As 60° to 70° of abduction is reached, there is a relative mechanical impingement of the supraspinatus tendon and subacromial bursa.

Attritional injuries to the supraspinatus tendon or repetitive motion may produce inflammation of the bursa. With attendant swelling of the bursa, the narrow interosseous tunnel produces still further impingement. When the bursa is inflamed and distended, the impingement upon motion is exquisitely painful. In time, calcific deposits appear in the supraspinatus tendon, causing further incitement of inflammation and increasing the bulk of the tissue attempting to glide between the humeral head and acromium.

Treatment is fairly well standardized. Cold compresses and rest are mandatory when tenderness is prominent. This may suffice. More often, improvement is slow. We rely heavily on the sterile aspiration of the bursa, followed by the instillation of one of the steroid preparations especially prepared for intraarticular injection. There is a new anti-inflammatory drug, indomethacin (Indocin), available which we have used for ten months with good results in the treatment of bursitis and tendinitis at various locations in the body. We have had no untoward side effects. Surgery is indicated for subacromial bursitis failing to yield to conservative measures. This usually consists of excision of the bursa, excision of calcific deposits, and repair of attritional injuries of the rotator cuff. Rarely, subtotal acromionectomy is required, but when done, it yields excellent results.

Calcific deposits may remain asymptomatic after the acute inflammation has subsided, in which event, we do not interfere. Occasionally, the calcific deposits will fragment and reabsorb with ultrasound therapy.

Another shoulder structure, the long head of the biceps humeri, frequently becomes inflamed. The tendon is restrained in the bicipital groove by a transverse ligament and is enclosed in a synovium-lined sheath. Inflammation produces swelling of the sheath and impingement of the tendon on motion. Local injection of steroids and administration of indomethacin have proven effective. We have not had occasion to operate for bicipital tendinitis.

The conservative modalities of treatment already discussed are apropos to the management of bursitis of the olecranon and trochanteric bursae. Operative treatment varies somewhat. In the case of the olecranon bursa, simple excision is all that is required, but skin closure and wound healing are complicated by the subcutaneous position of the ulna and motion of the elbow. The most common underlying cause of trochanteric bursitis is the presence of an orthopedic bone appliance used in the treatment of a previous hip fracture. If the fracture is healed, removal of the metal appliance facilitates control of the bursitis.

"Tennis elbow" is a lateral epicondylitis of the elbow near or at the origin of the common extensor mass of the forearm. Conservative treatment as outlined has proved satisfactory, and we have not had to resort to operative treatment of this condition.

In addition to bicipital tendinitis, another commonly affected tendon group are the abductor pollicis longus and the extensor pollicis brevis at

the anatomical snuff box. This condition is known as de Quervain's stenosing tenosynovitis. It responds well to rest, immobilization, and local instillation of steroids. Indomethacin has proven effective in this condition, especially when combined with the local instillation of steroids. Conservative treatment occasionally does not suffice. In this event, simple decompression of the common sheath of the two tendons by slitting it longitudinally is curative.

Rheumatoid arthritis is an inflammatory condition of joints, tendons, and supporting structures. The inflammatory response is usually intense. Joint synovium proliferates and encroaches upon the joint cartilage, eroding cartilage and subchondral bone. Secondary deformities occur, increasing the disability of the affected joints.

Synovial masses may commonly appear on the volar and dorsal surface of the wrists, the dorsum of the hand, the metacarpophalangeal, and proximal interphalangeal joints of the hand and the knee joint. Upon exploration, these masses are seen to be acutely inflamed and characteristic of rheumatoid synovitis. After excision of this rheumatoid synovium and pannus, joint destruction is usually found to be more extensive than suspected. Tendons are eroded; and some are ruptured. Articular surfaces are denuded of hyaline cartilage with loss of joint space and subluxation of joints. Bone matrix may be absorbed due to the hyperemic osteoporosis present.

Management of the rheumatoid arthritic patient is properly in the hands of the qualified generalist and internist. We see patients in surgical consultation and feel that we have something to offer them. In the early proliferative stage, we have found that injection of thiotepa (Thio-tepa) into the involved synovial cavities reduces the synovitis, improves the symptoms, and possibly averts joint destruction. This failing, we feel that early operative synovectomy is indicated. Once gross secondary deformities occur, reconstructive surgery is of benefit, but the opportunity to preserve function has been lost.

Osteomyelitis and Pyarthrosis.—The enigma of the orthopedic surgeon and of the family physician is osteomyelitis. Pyarthrosis is an equally foreboding problem. The earliest pathological changes in both of these conditions is inflammation. By whatever route access is gained, bacteria are seeded either into the joint cavity or into the metaphysis of a long bone. The bacterium is the insulting agent and the tissues respond with increased vascularity. With increased vascularity, there is tissue edema and hemostasis in the blood sinusoids of the metaphysis. This provides an excellent growth medium for bacteria, and with bacterial growth there is accumulation of pus. Increased pressure within the cortex of the bone leads to further bone necrosis. As the pressure increases, there is not only bone necrosis, but also a decrease in the blood supply. More importantly, it is difficult to deliver an antibiotic into the area.

Acute hematogenous osteomyelitis may be a difficult diagnosis to make. Nevertheless, the acutely ill child with fever, malaise, and bone or joint tenderness should be treated as a medical emergency until osteomyelitis and pyarthrosis have been proven not to be present. Supportive therapy in the form of rest, nutrition, and adequate blood replacement must be maintained. Blood cultures should be obtained on each occasion that the child spikes a fever until diagnosis is obtained. Needle aspiration of the involved joint or the periosteum in an osteomyelitis may produce the diagnosis if the lesion is well-localized. Once cultures are obtained, large doses of penicillin and sodium methicillin or other semisynthetic pencillin effective against penicillinase-producing organisms should be administered. Subsequent to a confirmatory culture, the inappropriate antibiotic can then be discontinued. If the child remains acutely ill after 12 to 24 hours of appropriate therapy, then surgical decompression is indicated in osteomyelitis. In the case of staphyloccal pyarthrosis, arthrotomy is indicated as soon as the diagnosis has been made. We continue antibiotic therapy for a six-week period subsequent to the lysis of fever.

Summary

We have demonstrated that inflammation of bones and joints is simply a reaction of that tissue to an injurious agent. The inflammatory response is characterized by a local increase in vascularity. Secondarily, swelling, increased heat, erythema, and tenderness are clinical manifestations of the tissue reaction.

General management of all inflammatory conditions consists of rest, immobilization of the injured

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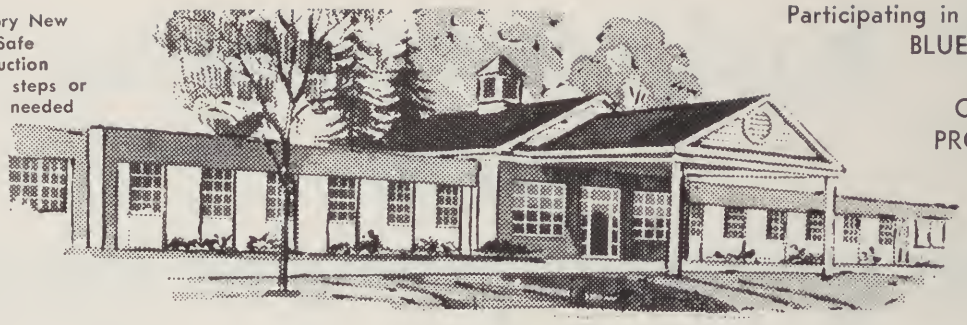
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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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part, application of cold compresses, and appropriate analgesia. Beyond these general measures, the treatment instituted must be individualized for the particular offending agent that has produced the inflammation.

In noninfectious conditions, the local instillation of steroids, aspiration of transudates, and use of anti-inflammatory drugs are of benefit. Occasionally, operative treatment is required to effect lasting relief. Treatment may be excision of bursae, excision of calcific deposits, removal of bone spurs and ridges, removal of metabolic implants, and release of constricting structures such as stenosing tendon sheaths and restrictive fascial bands.

In the rheumatoid arthritic, standard rheumatological drugs are recommended. In addition, joint instillation of cytotoxic poisons may effect a so-called chemical synovectomy. If the inflamed synovium does not respond to these measures, serious consideration for surgical synovectomy is indicated to preserve joint function and protect the surrounding soft tissues, especially the tendons.

In infectious inflammatory conditions of bones and joints, an emergent and vigorous therapeutic regimen is mandatory. Cultures of the offending organisms must be obtained by either blood cultures, aspiration of the lesion, or surgical decompression, and massive antibiotic therapy must be initiated and continued sufficiently long if cure is to be effected and chronic infection with its accompanying skeletal impairment is to be avoided.

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GENERIC AND TRADE NAMES OF DRUGS

Indomethacin—*Indocin*
Sodium methicillin—*Dimocillin-RT, Staphcillin*
Thiotepa—*Thio-tepa*

History of the Baltimore City Hospitals

BY DOUGLAS CARROLL, M.D.



Chapter 10.—The Baltimore City Hospitals Under Full-time Chiefs: Beginnings of Community Medicine. (1956-1966)

The record shows rather distinctly that the best medicine is practiced by salaried physicians in teaching hospitals, the best research is done by salaried physicians in government, university, hospital and industrial laboratories, and that salaries are no more dangerous to medicine than to nursing, engineering, soldiering, the courts, or the schools.[1]

With the appointment of the full-time chiefs and the increasing participation of the medical students in the middle 1950's, came a dramatic improvement in the number and quality of housestaff at the Baltimore City Hospitals. Research activities were developed on most of the services.

Since the close of the Sydenham Infectious Disease Hospital in 1950, the Baltimore City Hospitals had been the infectious disease hospital for Baltimore. All of Maryland's poliomyelitis patients were cared for at the Baltimore City Hospitals.[2] During the late 1950's and early 1960's, a number of exciting new discoveries and techniques were developed and put into use at the Baltimore City Hospitals.

The development of the Salk poliomyelitis vaccine in the late 1950's made the study of the poliomyelitis epidemic of 1960 of particular interest. Because of improvement in the diagnosis of poliomyelitis by the development of methods to identify the virus, only three cases of nonparalytic poliomyelitis were identified. Compared to previous epidemics of poliomyelitis, the epidemic of 1960 was particularly severe with widespread involvement of muscles. Twenty-five patients required tracheostomy and 24 had intermittent positive pressure ventilation. Ten patients had severe respiratory insufficiency, of whom six remained apneic at the end of three months. Seven patients died from bronchopneumonia, atelectasia or aspiration pneumonia. One patient has remained completely apneic and still requires artificial respiration.

In 1960, for the first time in the United States, the iron lung type respirator was completely replaced at the Baltimore City Hospitals by the use of positive pressure ventilation of the Moerch or Bennett type. This method of ventilating apneic patients was feared by many physicians familiar with the use of the Drinker respirator. During its development at the Baltimore City Hospitals, under the direction of the chief of anesthesia, Dr. Peter Safar, the advantages over the iron lung became evident. The patient could be reached easily by the nursing service and by the physical therapist, and felt far more comfortable and less claustrophobic. After 1960, the effectiveness of the Salk vaccine became evident, and the terrible epidemics which had plagued the world previously were eliminated.

Development of the positive pressure ventilation method of caring for apneic patients brought about the institution of an intensive care unit at the Baltimore City Hospitals. In this unit, special facilities were developed, such as respirators, piped-in oxygen, suction, monitors of various sorts with special nurses around-the-clock. This

was the first intensive care unit in the United States in which patients from any service with any acute disease could be admitted at the discretion of the housestaff.[3] The patients were cared for by the physician from the specialty service. The Department of Anesthesia, under Dr. Safar, acted as consultants on patients with respiratory problems in the intensive care unit. Dr. Safar's group also developed the use of mouth-to-mouth breathing.[4]

Controversies of the Fifties

The hospital became the target of a number of controversies and criticisms. A committee of the medical society conducted an investigation to find out whether physicians were practicing corporate medicine. This investigation was symptomatic of a widespread resistance on the part of practicing physicians to the practice of medicine by physicians on a salary. This method of practice was believed to destroy the valued patient-physician relationship, to demean the physician, and to undermine the private practice of medicine. Many thought it would lead to government control of medical care. The major objection, however, was that patients able to pay private or third party fees were being treated at a public hospital.

A second controversy arose over the relations between the Baltimore City Hospitals and the medical schools. The result was that the medical schools were given priority for *student teaching* on different services at the Baltimore City Hospitals but were given an equal responsibility in selection of chiefs of service.

A more recent controversy (1966) has been that brought about by a committee appointed by the City Comptroller to look into complaints by patients, their families, and nurses as to the operations of the Baltimore City Hospitals. This investigation was carried out by a citizen's committee which interviewed patients, nurses, and other hospital personnel but did not talk to any physicians. The major criticisms were aimed at the medical, nursing, maintenance, and housekeeping practices in the D Building (the large chronic hospital) and the fact that ambulatory patients with tuberculosis occasionally (and against hospital rules) went to nearby taverns, thus exposing the general population to tuberculosis.

The hospital administration and physicians had long been deeply concerned with the problems of staffing and renovating the D Building, but repeated requests for money to carry out improved programs had not been appropriated by the City Council. Baltimore City was in serious financial difficulty, and there was a nationwide shortage of nurses.

Full-time Chiefs of Service at the Baltimore City Hospitals

Pathology	1937	Dr. Frank B. Kindell
	1945	Dr. Gardner Warner
	1952	Dr. H. W. Keschner
	1953	Dr. Abou Pollack
Pediatrics	1945	Dr. Harold Harrison
Radiology	1945	Dr. Frederick Mandeville
	1946	Dr. Stanley Macht
	1949	Dr. John DeCarlo, Jr.
	1965	Dr. Gaylord Knox
Medicine	1952	Dr. George Mirick
	1962	Dr. Francis Chinard
	1963	Dr. Julius Krevans
Dentistry	1954	Dr. Glenn Waring
OB-Gyn	1955	Dr. Paul Molumphy
	1962	Dr. Frank Kaltreider
Anesthesiology	1955	Dr. Peter Safar
	1961	Dr. Thomas DeKornfeld
	1963	Dr. Joseph Redding
Surgery	1956	Dr. Mark Ravitch
	1965	Dr. Richard Steenberg
Tuberculosis	1956	Dr. Edmund Beacham
Physical Medicine and Rehabilitation	1956	Dr. Douglas Carroll
Psychiatry	1961	Dr. John O. Neustadt
	1965	Dr. Robert Ward (Acting)
Gerontological Research Unit	1940	Dr. Edward J. Stieglitz
	1941	Dr. Nathan Shock
Chronic & Community Medicine	1963	Dr. Mason Lord
	1966	Dr. Lawrence E. Shulman

The problem of control of patients with infectious tuberculosis went much farther than patients wandering down to Eastern Avenue. Although Baltimore has for many years led the nation with its high tuberculosis rate, it was not until 1959 that the Health Department began to use the courts to commit patients with open tuberculosis (who refused hospitalization or treatment) to a tuberculosis sanatorium.

A third criticism that patients with open tuberculosis had been knowingly mixed with general non-tuberculosis patients without isolation could not be substantiated by the hospital staff.

Although generally censorious of the Baltimore City Hospitals' efforts to provide excellent medical care to the chronically ill, the report must have made clear to the committee and to municipal authorities that to accomplish its purpose, the hospital will require huge appropriations over the next few years to bring its buildings into repair, to raise salaries, to create new positions and generally to improve the amenities of the hospital. The patients who come to the hospital under the Medicare program will no longer be welfare clients but will be private patients demanding not only good acute medical and nursing care but also the pleasant surroundings, privacy, and personal attention offered by the smaller, newer community hospitals.

The hospital underwent a number of other investigations during 1966. An official team of the American Hospital Association reported, "The citizens of Baltimore should be proud of the fact that not only are (Baltimore City Hospitals) furnishing top quality medical care for their indigent but also are doing more than their share in training doctors to meet their community's and the country's needs for qualified medical practitioners." This committee agreed that there were too few nurses and that the attitudes of supervisory personnel needed improvement.

In June, 1966, the Joint Committee of Accreditation of Hospitals approved the hospital for the maximum (three years) period, and the Maryland State Department of Health approved the Baltimore City Hospitals for Medicare.

* * * * *



Fig 20

Medical and Associated Services (Psychiatry, Chronic and Community Medicine, Physical Medicine and Rehabilitation) at Baltimore City Hospitals 1962-1963: 1. Alexander Townes, 2. Patricia Smith, 3. Alice Bessman, 4. Edith Schoenrick, 5. Mason Lord, 6. Jimmy Zachary, 7. Francis Chinard, 8. Thomas McGonagle, 9. Howard Rathbun, 10. John Neustadt, 11. Marvin Schuster, 12. Hazen Kniffen, 13. Douglas Carroll, 14. Albert Christlieb, 15. Thomas Kahn, 16. Paul LaRaia, 17. Richard Taylor, 18. Bernard McGowan, 19. Steven Lipson, 20. Prospero Flores, 21. Michael Brand, 22. Alan Gill, 23. Juan Alva, 24. Baruch Schmidt, 25. Reuben Siraganian, 26. Masao Honda, 27. Paul Lenz, 28. George Loufti, 29. Leslie Fenton, 30. Ezequiel Salinas, 31. Vincent Felitti, 32. James Sowa, 33. Barbara Solomon, 34. Jerome Cooper, 35. Robert Herb, 36. Myron Glovsky, 37. Robert Shikes, 38. Leslie Weiner, 39. Anoush Miridjanian.

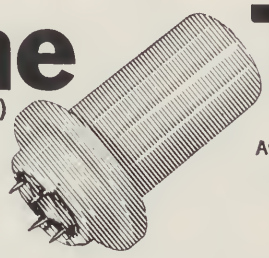
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I believe that responsible investigations of the hospitals not only are appropriate in a public institution but over the years have served a useful purpose. "No institution," writes Titmuss, "continually in a state of change, constantly subject to the pressure of many vested interests and forces, can hope to remain healthy without criticism. . . ."[5] Investigations of the Baltimore City Hospitals have never uncovered any serious problem which was unknown to the hospital authorities and which efforts had not been made to correct. Investigations have frequently mustered public opinion to support the hospitals' needs where requests through standard channels have been ineffective. For, although the hospitals have generally been consistently supported by the medical schools, the elected city officials, the medical society, and the hospital (or welfare) board, Baltimore residents have sustained little or no pride in the Baltimore City Hospitals. This lack of interest in the Baltimore City Hospitals is partially explained by the fact that it was first an almshouse, then an insane asylum, and more recently a hospital for welfare clients. The publicity for the hospital has been very poor. The Baltimore City Hospitals is in the news only when some deficiency is discovered. Possibly the use of the hospitals by patients on Medicare will result in more public attention and improvements.

Medical Teaching

This controversy was in part a manifestation of the needs of the medical schools for patient material for their students and for more teachers. The welfare patients at the Baltimore City Hospitals needed the services of medical students and did not object to being examined by them. The growth of coverage by Blue Cross and Blue Shield placed many of the ward ("free") patients in the university hospitals in the category of semiprivate patients. These patients were considered less desirable teaching material.

Furthermore, the full-time physicians at the Baltimore City Hospitals were willing and eager to teach students. Since their salaries were paid by the City of Baltimore, they swelled the ranks of potential teachers without cost to the medical schools.

Medical students were making an increasing contribution to the care of patients at the Baltimore City Hospitals. In 1953, the Johns Hopkins third year medical students had become fulltime clinical clerks on the medical wards. Students also participated in the activities of the Pediatric, Surgical, Anesthesia, Obstetrics and Gynecological Departments. In 1963, the University of Maryland medical students who previously had worked in the Outpatient Department and as parttime clinical clerks were given a three-week period on the medical wards as fulltime clinical clerks.

An observer from England studying medical education mainly at the Johns Hopkins Medical School compared the instruction of the United States schools with that of the British schools. He noted the heavy emphasis on student research in the American schools but thought that the instruction in the history taking and physical examination was not emphasized sufficiently. The case history was described as going into amazing detail, but the author thought that the student was often submerged in a sea of confusing data. The individual instruction of students, oriented around the patient at the bedside, was considered a superior method of teaching. He noted that the American student sees fewer patients than the English student but studies them in more depth. He thought that the use of welfare patients as material for student teaching led to little understanding of the social aspects of the patient's illness. One of the greatest compliments he paid the American system was the lack of formality and the questioning of authority and dogma by the American medical student.[6]

Under the direction of Drs. Mirick, Chinard, Harrison, and Neustadt, a family practice (two-year) internship was introduced at the Baltimore City Hospitals in 1960.[7]

This was the first such program in the United States. It was designed to give the physician experience with patients from birth to old age. Psychiatry was emphasized in addition to internal medicine and pediatrics. The program was supported in its early years by the Kellogg Foundation. The program served a useful purpose and has been continued.

Rehabilitation and Community Medicine

Late in 1954, the last physical therapist resigned. After a study of the needs for physical therapy, a

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which a 200 to 1 ratio as compared to chlo thiazide..."[13]

Moreover, due probably to its virt lack of carbonic anhydrase inhibiti Naturetin (bendroflumethiazide) been shown to cause less potassium a bicarbonate loss and less alteration urinary pH than either chlorothiaz or hydrochlorothiazide.

Naturetin is outstandingly effect not only in establishing, but also maintaining, excretion of retained fl in edematous patients. And its durat of action is sufficiently prolonged allow a single daily administration most patients. Naturetin is also an effective antihypertensive agent.

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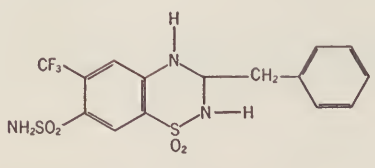
Warning: Ulcerative small bowel lesions ha occurred with potassium-containing thia preparations or with enteric-coated potass salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting G.I. bleeding occur.

Precautions: The dosage of ganglionic blo ing agents, veratrum, or hydralazine wh used concomitantly must be reduced by least 50% to avoid orthostatic hypotens Electrolyte disturbances are possible in rhotic or digitalized patients.

Side Effects: Bendroflumethiazide may ca increases in serum uric acid, unmask diabe increase glycemia and glycosuria in dia patients and may cause hypochloremic al losis, hypokalemia; cramps, pruritus, parest sias, and rashes may occur.

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recommendation was made to establish a Department of Physical Medicine and Rehabilitation at the Baltimore City Hospitals. This department was started in 1956. Its main purpose was to make certain that all patients of the Baltimore City Hospitals attained the highest degree of independence and returned, if possible, to home, family, and job.

The rehabilitation movement had opened the possibility for greatly improved medical care. Instead of paying patients off for injuries and impairments and thus ending society's responsibility, the rehabilitation movement emphasized the need to re-educate the patient and return him to the industrial stream.

Yet, rehabilitation did not answer the problems of patients without "rehabilitation potential." A number of social forces were creating a group of elderly, chronically sick persons who could no longer be cared for by their families and whose lives were prolonged because of improved medical diagnosis and treatment.

Families were living in smaller urban housing which did not allow room for the elderly members of the family. The working wife could no longer double as nurse.

An event of great importance to the Baltimore City Hospitals was the laying of the foundation of a long term program for the care of welfare patients with chronic diseases. The philosophy underlying this program was that the hospital is not a place merely to diagnose and usher the chronically ill, elderly patient into the next world, but the place in which prevention, diagnosis, treatment, and appropriate placement of patients with chronic diseases should be centered.

For nearly two centuries, the almshouse, then asylum, and finally hospital, had been concerned with the problems—medical, psychiatric, and social—of unwanted people—orphans, vagrants, the insane, the tuberculous. In this effort, the state had given relief and concerned attention. The new problem was the growing number of elderly destitute people with chronic diseases. The state had started three chronic disease hospitals for the care of patients with "rehabilitation potential," but this effort did little for the quantitatively more serious problem of those who did not have rehabilitation potential. For years, the Baltimore City Hospitals had given these patients shelter, nursing, and medical care, but most patients remained permanently in the institution and a large waiting list developed.

Dr. Mason Lord, who saw these problems at first hand as medical resident in 1958, started with vigor and imagination to meet them. No longer must the hospital and university stand aloof from community public health problems. His program was based on the following principles:

1. The care of these patients must be hospital-based, using all community resources possible. Cases must be discovered, diagnosed, and treated early to prevent deterioration.

2. Once accepted, patients must be observed permanently for coordination of social and medical problems and to insure that the benefits of early and expensive investigation and treatment not be lost.

3. These patients should be given the best possible diagnostic and social workup on acute medical wards. Since these patients make up a large part of the load of internal medicine, they should form an integral part of the training program of housestaff and medical students on medical wards of teaching hospitals.

4. The special services of the hospital—diagnostic, surgical, rehabilitative, and social—must be used to the hilt. That is, the patient, once having been evaluated and started on treatment, must be placed in facilities, ie, homes, foster homes, nursing homes, or apartments, when such facilities are available, but hospital beds must not be filled with nursing home patients.

5. This area of medical-social effort is as valid for intellectual endeavor and research as in any other academic field and must be informed by research and training of physicians, nurses, and social workers.

Dr. Lord was made chief of his newly founded Department of Chronic and Community Medicine in 1963. He established rapport with practicing physicians, with clinics, and with hospitals to find patients in need of this comprehensive preventive and treatment approach. All applications to the State Chronic Disease Hospitals and to the Baltimore City Hospitals were evaluated, and the decision was made as to where they would receive the most appropriate treatment.

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home, nursing home, or foster home. The old infirmary (D Building) was renovated to care for patients during convalescence while awaiting transfer to a nursing home. Plans were made for the development of an old age center, foster homes, and nursing homes.

Under the impact of this dynamic and creative program, a new dimension was added to the stature of the hospital.

In 1959, Mr. Parker J. McMillin retired from the Baltimore City Hospitals after many years of devoted service. He was succeeded by Mr. Frederic G. Hubbard. In the same year, Miss Mazie Rappaport was appointed director of social service and was able, over the years, to build up a distinguished Department of Social Service. Continued improvements were made in medical records and various administrative sections of the hospital as well as in the professional departments.

In 1963, an addition to the acute hospital was begun. This had been financed by a bond issue several years before. The addition was designed to contain sterile supply, records, pharmacy, clinical laboratories, new operating rooms, Department of Anesthesiology, premature baby unit, well baby unit, and obstetrical delivery suite. This unit was opened in July, 1965.

A plan was started to supply professional garden apartments for housestaff on the property of the Baltimore City Hospitals. This unit was opened in May, 1965.

A new $8,000,000 research building for the gerontological unit was started in 1966.

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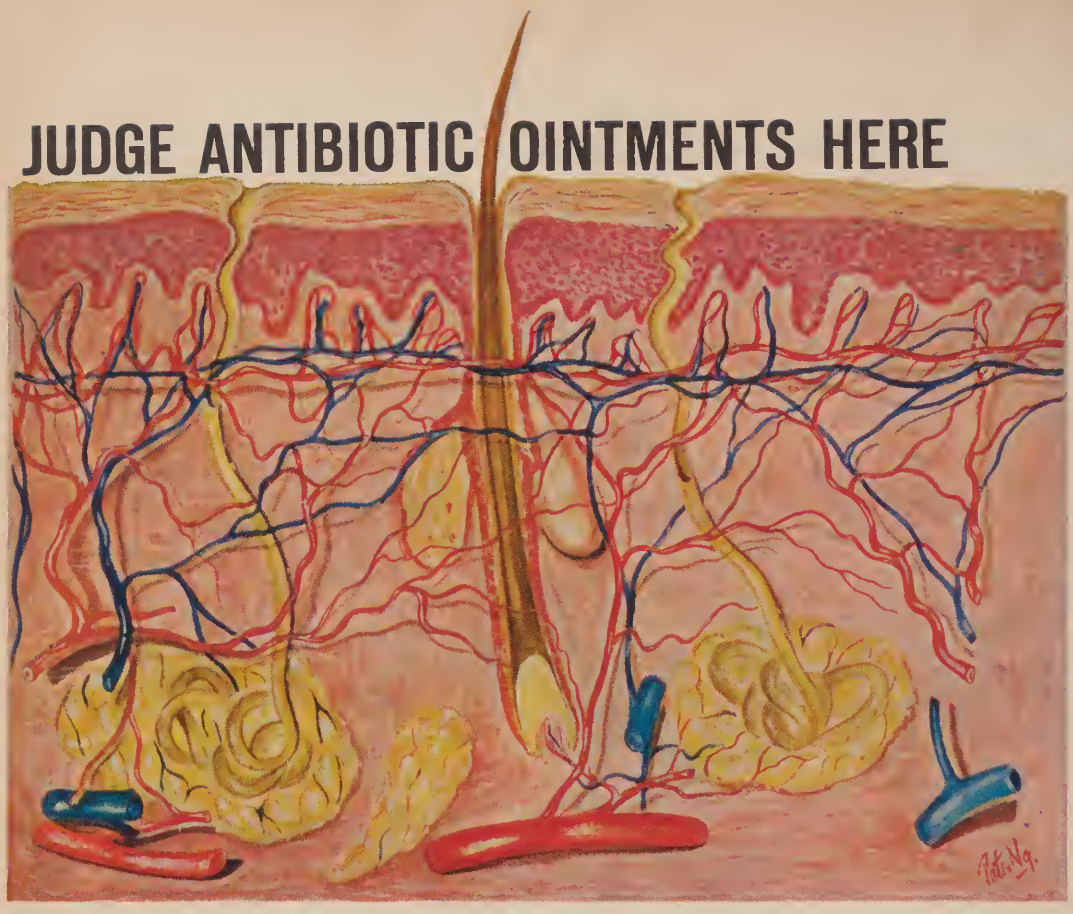
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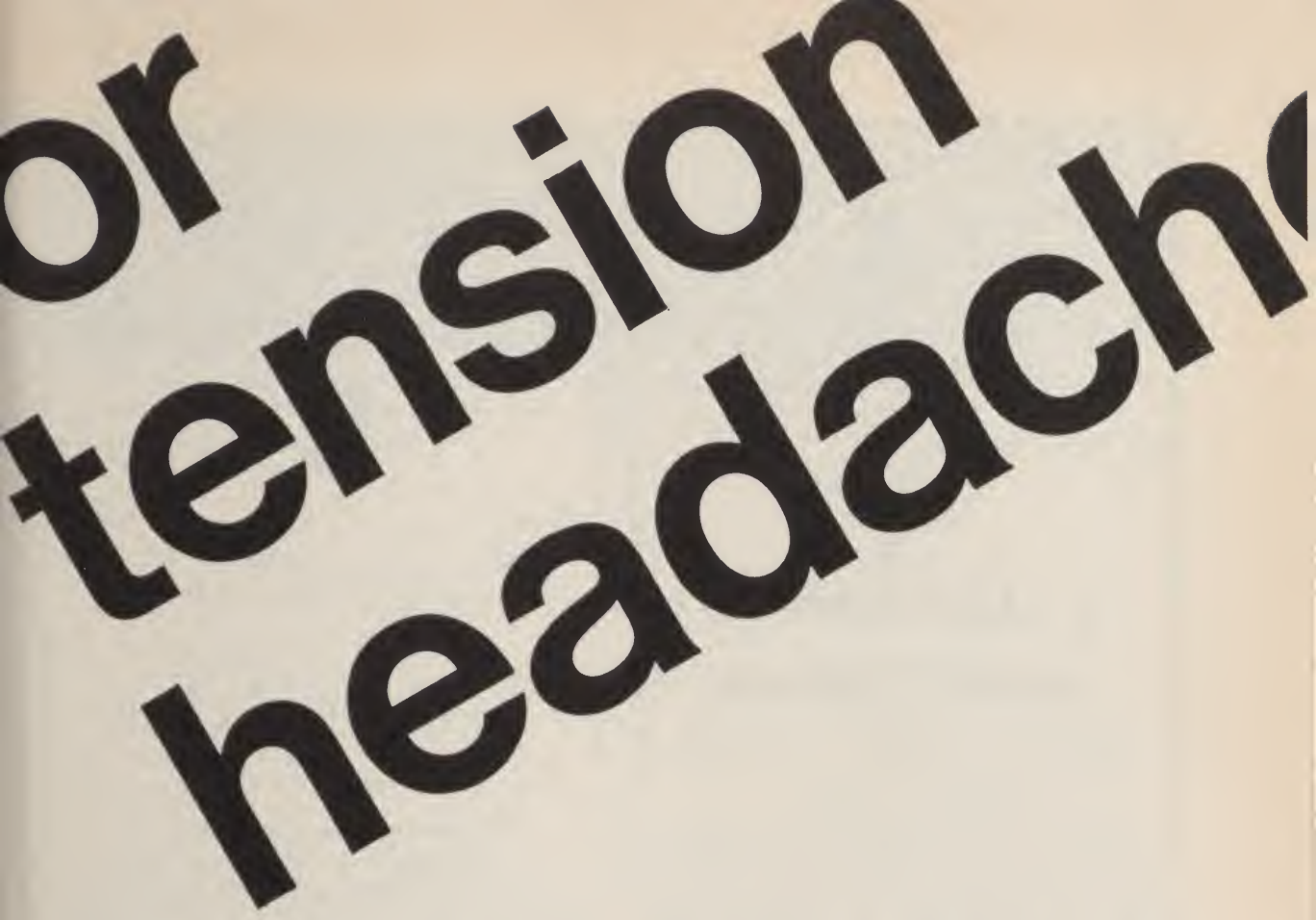
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ACCIDENTS IN CHILDREN: WHAT CAN WE DO ABOUT THEM?

THOMAS E. REICHELDERFER, MD
Chairman of the Committee on Accident Prevention and Poison Control Centers, Maryland Chapter American Academy of Pediatrics

While the rate of accidental deaths in children decreased 30%[1] in the decade 1953-63, accidents exceed diseases as the cause of death of the nation's youth. Much of this reduction has been due to the continuing efforts of physicians, safety programs, pharmacists, public health departments, national safety councils and associated groups, and other interested agencies; but there is still a continuing problem to be met in bringing about a further reduction in unnecessary deaths, crippling, and injury to our youth.

Accidents are the main cause of death in all age groups up to age 44.[2] Motor vehicle accidents account for most of the accidental deaths in the older age groups.

Most accidents in children 1-4 years old are the result of pulling objects off tables or stoves, being left alone in homes without responsible adult supervision, and playing with matches. Approximately 21% of about 5,100 deaths in 1962 were from fires and explosions. Second and third causes of death in this age group, about 14% each, included drowning and motor vehicle accidents to pedestrians. Children in this age group escape supervision and run into the path of oncoming cars or fall into bays, rivers, lakes, or swimming pools. Poisoning and falls killed approximately 500 more children. The risk of accidental death is greater for boys than for girls, and greater for non-white than white children.

Three-fifths of approximately 14,600 deaths from accidents in teenagers and young adults (15-21 years) involved motor vehicles. Another 1,200 were drowned, and 600 were killed by firearms.

Physicians can, upon entry into homes, suggest prevention of hazardous situations when they exist. They can advise mothers that the discipline of obedience in the child is an important safety tool and that the small child must be protected until he is old enough to care for himself. Parental responsibility must also be stressed. Baby sitters should be able to contact parents and should have available the police, fire, and physician's telephone number in case of emergency.

Prescribing only sufficient medication to treat an illness and insisting on proper labeling and disposal of the medication after it is no longer needed are part of the physician's responsibility. Medicines, especially aspirin, and home cleaning agents are the leading causes of accidental poisoning. Medications should be locked up and

cleaning agents kept out of reach of children. Pamphlets and other material relating to the prevention of accidental poisoning and other hazards could be placed in the waiting room for patients' reading.

Three children died of accidental poisoning in Maryland last year. The Poisons Information Centers in the state assisted 3,161 people with problems of poisoning. A Maryland Poison Information Center with a full-time staff has been established at the Baltimore City Hospitals. This center operates 24 hours a day, seven days a week, and gives instructions for emergency first aid and accidental poisonings. The establishment of this center is the result of cooperation between the Maryland State Health Department, the Thomas Wilson Foundation, and the Maryland Chapter of the American Academy of Pediatrics. It can be reached by calling DIckens 2-0800.

Physician's should take a greater interest in automobile design and safety and should insist that local and state traffic laws be enforced. They can also support driver education and safety programs. Young people should be encouraged to learn to swim. The American Red Cross and the Young Men's Christian Association teach many children to swim each year. When the physician sees firearms in the home, a word of warning to the parent often will prevent a catastrophe.

By supporting programs outlined above, physicians have been responsible for much of the reduction in accidental death in children. The program is one on continual parental education and vigilance. Please continue with your efforts.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Home Rehabilitation of the Stroke Patient

JOHN E. GESSNER, MD

Assistant Professor, Division of Physical Medicine and Rehabilitation
University of Maryland School of Medicine.

Rehabilitation, like any other therapeutic technique, may be an extremely complicated procedure. But just like appendectomy, it usually is not, and when applied appropriately, it is effective.

When used in treating the disabilities associated with stroke and similar syndromes, it is most effective when applied as an effort to teach patients to perform activities of daily living and ambulation. For the patient with moderately severe hemiparesis—and minimal or no impairment of intellect or memory, the most effective techniques are those partly developed and currently practiced in the chronic disease hospitals of the Maryland State Health Department. This program makes little or no use of complicated and controversial exercise programs designed to "stimulate" new neuronal pathways for the return of function.

A common sense approach is used, that is, teaching patients to use their remaining function to feed, dress, and bathe themselves and to get around in a wheelchair, or more usually to ambulate safely with whatever bracing and appliances are necessary. A patient with no function in an upper extremity and only poor hip flexion and knee extension, with moderate spasticity, usually requires a short leg brace and cane. When possible, hemiparetic upper extremities are trained as helping hands, but in the moderately severely involved patient described above, function rarely returns in the upper extremity.

My experience with the use of speech therapy in the treatment of aphasia has been that, if spontaneous return of speech does not occur, the therapy is of psychological value, at best. This is particularly true in those patients with severe involvement characterized by loss of auditory recognition. Some speech pathologists maintain that the best speech therapy for the patient with stroke is in his home environment with relatives and friends as therapists.

Senile patients with symptoms of extensive cerebral arteriosclerosis, including poor memory, short attention span, and lack of judgment, obviously do not do well in a program in which the

patient's contribution to success consists of learning and doing. However, cerebrovascular stroke is a dynamic syndrome with a great tendency for recovery, and patients who have early confusion, incontinence of bowel and bladder, or poor body balance often improve and on this account should not be denied a trial of therapy.

As part of a project by the Harford County Heart Association to develop a home program of therapy for patients with residual disability from stroke, a registered nurse from the county spent three months at Montebello State Hospital learning chronic disease nursing care on the wards, self-care and ambulation techniques in the physical therapy department, and teaching of the techniques to the patient under supervision. She was taught to use the Barthel index[1] in evaluating patients' abilities. The program was then publicized to the physicians of Harford County, who were responsible for formal referral for therapy. As consultant in physical medicine and rehabilitation to the program, I saw the patients and sent to each one's physician a written report of findings and prognosis, including prescription plan. Whenever possible, the physician was invited to attend the evaluation. In addition, the therapist was required to report to the physician concerining the patient's progress.

Of the first 20 patients seen, 11 became independent in activities of daily living and ambulation. Nine of these 20 were younger than 65 and of this group, seven became independent and two died. Eleven were older than 65, and only four became independent. Six of this group died. Thus. 55% of the patients in the series became completely independent in activities of daily living and ambulation using criteria of the Barthel index. The average treatment time for this group was one and a half months. Early in treatment, therapy was carried out daily. This average time would seem to approximate an adequate trial. In this group, youth (65 or under) was the best prognostic sign. Only two patients were aphasic, and these were among the patients who died.

The death rate of 40% one and a half years later is not excessive,[2] since some of the patients were seen within days after the onset of stroke. Exercise was graded, and patient tolerance was gauged on the basis of respiratory rate and pulse. No referred patient was refused treatment. The fact that patients with permanent brain damage with intellectual deterioration do not become independent was borne out in this study.

An almost universal problem was getting the patient out of his hospital bed, where he was immobile, into a standard height bed with a firm mattress (or bed board), so that transfer activities could be started. Once the family realized the ease with which the hemiparetic patient could be moved from bed to a wheelchair and then to a commode, they became enthusiastically active in the program.

No special equipment was used, and the therapist's ingenuity substituting bed rails for parallel bars and using ramps in the home made it unnecessary. A wheelchair was available early in the program, and was removed when the patient became ambulatory. Homemaking training was done in the patient's own kitchen. Foot drop braces were manufactured for the patients in Baltimore. Patient funds were always used when available.

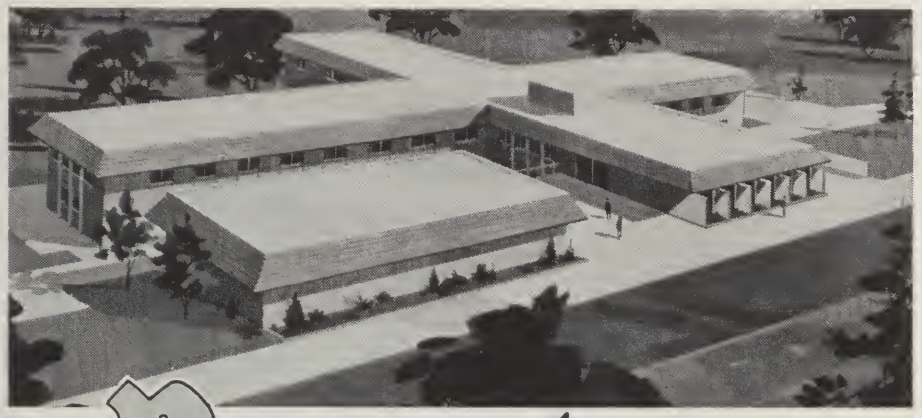
Conclusions

Rehabilitation at home is possible for patients disabled from stroke and, for the average family, it is desirable.[3] The patient does not leave the family circle, nor does he become a disposition problem for the chronic disease hospital. Rehabilitation can be done with a minimum of equipment. It consists essentially of showing patients how to use remaining functional abilities, of which they often are unaware.

The rehabilitation team should comprise the family physician and a therapist who concentrates on teaching activities of daily living. The rehabilitation facilities of the chronic disease hospitals may be used for those patients who do not improve after adequate trial or for consultation during treatment at home.

These same techniques could be used for patients with orthopedic problems of hip fracture, for example, and for patients with incapacitating rheumatoid arthritis. Further controlled study should be done on larger groups, and the effects of socioeconomic status on results should be studied, since this study was done on a small homogeneous middle class group.*

*This study was made possible through support of the Harford County Heart Association.



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Summary

Twenty patients who had sustained cerebrovascular stroke were given training in activities of daily living and ambulation in their own homes, as part of a home rehabilitation program. Ages ranged from 45 to 93. Eleven, or 55% of the group, became independent in activities of daily living and ambulation. Eight patients had died by one and a half years later, two of whom had become independent. Three patients were transferred to nursing homes.

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THE MEASLES VACCINE IN PREVENTION OF MENTAL RETARDATION

Ten-year-old Kimela Jean (Kim) Fisher is this year's poster child. Kim, daughter of Mr. and Mrs. Guy William Fisher, of Fort Wayne, Ind., was a bright child until she was two, when she developed measles encephalitis. The inflammation of the brain caused mental retardation and defects in vision and hearing.

Measles is the most serious of the childhood infectious diseases. Four million children get measles every year. Some 500 children die of it; of the 4,000 who develop measles encephalitis, 1,600 become mentally retarded. One in six develop serious respiratory illnesses, including pneumonia, which is responsible for most of the infant deaths from measles. More than half of the four million children who have measles suffer some form of brain involvement, as indicated by abnormal electroencephalographs taken during the course of the disease. Though the EEG's go back to normal when the children have recovered from the measles, researchers still do not know what changes may have taken place in the meantime.

Three years ago, measles vaccines were licensed by the United States Food and Drug Administration. Thus there are now safe and effective means to eradicate this cause of mental retardation and other handicaps.

This year, therefore, the National Association for Retarded Children (NARC) is urging its member units to cooperate with physicians and health agencies in reaching the more than 12,000,000 children of susceptible age (nine months to 12 years) who have not yet been vaccinated.

NARC units can be helpful in promoting measles vaccination through their public information and other programs. A fact sheet, "What You Should Know About Measles and the Measles Vaccines," has been prepared by NARC. The fact sheet includes a list of 87 immunization projects in state and local health departments which have been supplied with measles vaccine by the United States Public Health Service. There is no charge for the vaccine, but in some areas parents may be required to pay a small fee.

The NARC Public Health Services Committee set forth as one of its objectives for 1966 to urge the inclusion of measles vaccination in each child's immunization program.



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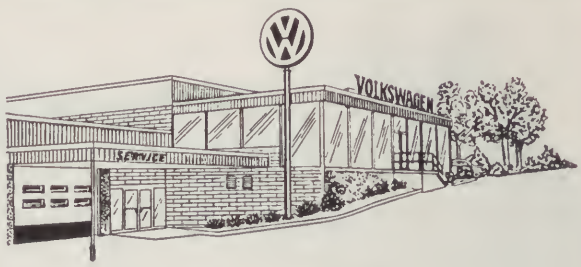
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

THE ALCOHOLIC TREATMENT PROGRAM AT CROWNSVILLE STATE HOSPITAL

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Coordinator, Services to Alcoholics
Maryland State Department of Mental Hygiene

In most states, professional services to alcoholics were initiated in response to one pioneer voice crying out in the wilderness of ignorance about alcoholism and neglect of alcoholics. In Maryland, that voice some 15 to 20 years ago was the voice of an analytically trained and oriented psychiatrist, Dr. Isadore Tuerk, now Commissioner of Mental Hygiene. When Dr. Tuerk was Superintendent of Spring Grove State Hospital, he organized a separate unit for alcoholics. That was 17 years ago, and Mrs. Marty Mann has said that it was the first of its kind in the country. Dr. Tuerk himself gives full credit for the development to a group of Alcoholics Anonymous members who suggested it to him to make their Twelfth Step job in the hospital easier and more effective.

For the past five years, Maryland has had four such special units, one in each of its regional mental hospitals. The Crownsville Unit is the biggest and most comprehensive of the four, and so far, the only one with beds for women alcoholics. Crownsville is a 2,000 bed State psychiatric hospital, serving four southern Maryland counties and one-third of Baltimore City, the third in which Skid Row is located.

The Alcoholic Rehabilitation Unit is located in two two-story red brick cottages with open doors, quite separate from the rest of the hospital. The second floor of one cottage has been partitioned to provide a 22-bed dormitory for women. The remaining 108 beds, including the Sick Bay for the acutely intoxicated, are for men. (Newly admitted women alcoholics needing emergency medical care are detoxified in the Medical and Surgical Unit.) The cottages are relatively comfortable, and have sufficient space for the program carried on in them. The alcoholics themselves keep their quarters clean, painted and in good repair; and provide a number of "luxuries" not included in the regular hospital budget, such as coffee makers and an unlimited supply of coffee, AA posters and pamphlets, radios and televisions, recreational equipment, etc. Men and women participate jointly in all activities.

The physical plant is perhaps the least important feature of an inpatient alcoholic program. The essential features might be listed as follows:

1. Selected staff with a variety of skills,

Delivered at the University of Colorado School of Alcohol Studies, June 21, 1966.

2. An open-door admission policy,

3. Individualized evaluation and treatment of patients,

4. A broad variety of treatment, involving the individual patient's own resources—his own strengths, skills, family, etc.,

5. Pre-release planning with community collaboration,

6. Realistic goals, and,

7. Attention to public education, professional training, and research.

In the Crownsville program each of the seven features contributes to the quality of the counseling service.

Most of the staff are self-selected—they have *chosen* to work with alcoholics. Some who had not originally chosen their assignments to the Unit, have, after exposure to the program, become its most devoted exponents. Their feeling for alcoholics leads them to welcome the partnership of AA members and of the patients themselves. The program process, as described below, is designed to develop a kind of harmony of point of view, a homogenized philosophy, among staff members and to keep communications open among them.

A wide variety of skills are represented on the staff. The administrator-coordinator is a psychiatric aide, a member of AA. Two other AA members are psychiatric aides, and the psychiatric aide assigned to assist the administrator is a member of Al-Anon. The nursing supervisor is a licensed practical nurse. There is a full-time medical director, an internist; a full-time psychiatrist, a resident who spends three months of his residency in the Unit; two full-time trained social workers; and the services as needed of an industrial therapist, a vocational counselor, a chaplain, psychologists and, of course, the various medical specialists who serve the whole hospital population.

The Superintendent of Crownsville, Dr. George McK. Phillips, sees his hospital as offering a community service, and to serve the needs of alcoholics, who have never been known to adjust their drinking practices to professional office hours, the hospital has an open-door policy. Alcoholics (who account for about 50% of all admissions) are admitted any time of the day or night, whether drunk or sober, whether male or female, whether on voluntary request, on two doctors' certificates, or by court order, whether they are first admissions, or are coming in for the 10th or 12th or 20th time. At least one-half the alcoholics are admitted on voluntary request, but for most of them, the term "voluntary" is in quotation marks: somebody has pushed from the outside—usually a wife, or an employer, or a judge.

Individualized evaluation and treatment is assured for every alcoholic patient by a process of daily staffing of newly admitted patients. Because this process is the heart of the Crownsville program, some account of it is appropriate. Every morning at 9:00 AM, the staffing group meets. Present are the medical director, the psychiatrist, at least two representatives of nursing service, and a social worker. The industrial therapist is usually there, and the vocational counselor is there twice a week. The focus of the group is on the alcholic's here-and-now-reality, his present pain; except in very rare instances, little attention is devoted to family background or early childhood history.

The nursing supervisor, with the charts in front of her, reports on the admissions in the past 24 hours—usually five or six or seven. On a Monday morning there may be as many as 30.

One by one, each new admission who is well enough to do so, joins the group. He is introduced to the group and made to feel at ease. The medical director usually opens the interview, but everyone participates, raising the questions relevant to his function in the Unit. General questions asked include: What brought you to the hospital? What help do you want, or hope or expect to get here? How long do you plan to stay, and what plans do you have for leaving? If the patient has had previous admissions, the interview will be concerned with his experience since his most recent release: what had gone wrong with the plan with which he left, or perhaps, what had helped him stay sober for as long as he had.

There is worthwhile book material in the stories told at these sessions. The predominant feeling is fear. The alcoholics are frightened men and women. They are afraid to drink and afraid to stop drinking; they have been afraid to enter the hospital and are afraid to leave it; most of all, and universally, they are afraid of the future, because every one of them is aware of what has

been called "the exquisite predictability" of the alcoholic career: every one knows the fate that threatens him.

Before any patient leaves, the staff share a pretty good idea of his strengths and weaknesses, and have shared with him some treatment plan. For every patient the plan includes medical care, exposure to AA, attendance at educational meetings, involvement in Patient Self-Government, and a hand-tailored industrial assignment. For every patient it also includes assignment to one particular counselor (who may belong to any of the disciplines represented on the staff) to whom he may turn at any time he wants or needs individual help. For any one patient the plan may include any combination of a number of other services: family counseling by the social worker or the special counselor, help in settling unfinished business left behind on admission, psychological testing, social casework, group counseling, psychotherapy, pastoral counseling, vocational counseling (which may or may not lead to vocational rehabilitation), industrial assignments outside the hospital to earn money to finance release arrangements, trial home visits, and medication, including disulfiram (Antabuse). Occasionally, it can be arranged for a patient to use the Unit as a day-hospital or a night-hospital.

Discussion of each patient's length of stay is by no means academic. By law, the hospital may not detain an alcoholic patient for more than seven days after he has written the superintendent of his intention to leave; and by administrative policy, the same ruling applies to those who are admitted on two medical certificates. Those on court order have less freedom of choice, but the recommendation of the staff can, if it seems desirable, influence the Court's decision.

The average length of stay is four to six weeks, but the range is from three days to six months, or more. Most often, in perhaps 80% of the cases, the length of stay of any particular patient is a result of consensus between patient and staff. In the case of the alcoholic who has stayed sober for five years in AA before one slip brought him to the Unit, there is little point in keeping him longer than the three days he needs to detoxify and then sending him back to his family and his job, with the realistic hope that he will again stay sober for another considerable period of time. On the other hand, when it has been determined that a young alcoholic who is both bright and sensitive, is a functional illiterate, there is good reason to believe that adult education may help him find more satisfaction in a sober life, and learning to read and write takes several months. Among the alcoholic patients are those irreversibly damaged who will be in the hospital for life, but these patients are not housed in the Alcoholic Rehabilitation Unit.

Everyone who has worked with the staff at the Crownsville Unit, observed their work, or talked with their patients individually or in groups, is satisfied that enormous effort, compassion, ingenuity, imagination and pride go into this man-tailored (and woman-tailored) evaluation and treatment process. The staffing is a guarantee, repeated daily, that the Unit program is patient-centered, and that the staff work together toward goals jointly selected and accepted by them and the patients.

From experience with hundreds of alcoholics, the Crownsville staff have learned to be satisfied with partial goals. For one patient it may simply be keeping out of jail; for another, staying sober enough to hold a job; for a third living, perhaps on Welfare, on the dry island of a halfway house. Relapses come as no surprise. Indeed, if they are six months apart, they may prove a source of gratification, evidence of unexpected motivation in a patient who had not been sober for a week at a time for the past 20 years. Former patients who have become active in AA are encouraged to come back to the Unit to encourage those who have not yet found their way, and often serve as sponsors to patients on their way out.

Some time before the release date agreed upon at staffing, the patient's own counselor starts reaching out to the resources in his home community which may be able to help him stay well and to maintain whatever gains he has made in the hospital. The resources involved depend on both the patient and his community. Potential allies include a spouse, an employer, a welfare worker, a probation officer, a landlady, a public health nurse, an alcoholism or mental hygiene clinic, a clergyman, a half-way house, a family physician, an AA group, a private social agency, a council on alcoholism, or any combination of such resources. No patient leaves the Unit until it is determined that he has a place to live and some assurance of

an income.

Unfortunately, family counseling is only a minor feature of the inpatient program. In the first place, only about 20% of the alcoholic patients still have connections with their families; and in the second place, the geographic location of the hospital makes it difficult for some families to visit, and the hard-pressed staff have limited time to visit families. If the patient agrees, the staff may ask that an Al-Anon member visit his spouse. Such visits have helped in a few dramatic cases, but there are not yet enough Al-Anon members, and most of them are middle-class people who are not entirely comfortable with lower-class families and their problems.

Who counsels the alcoholic in Crownsville? Anybody and everybody on the Alcoholic Rehabilitation Unit staff, and more and more often it is happening that the alcoholic leaving the hospital keeps in touch with the particular counselor who has had some impact on him. Needless to say, patients also counsel other patients, especially those who work in the Sick Bay as orderlies and help the acutely intoxicated through their crises.

The final element listed above is professional training, public education, and research. These three activities are not just icing on the program cake, but are indeed more like vitamins that enrich it. Within the hospital, psychiatric residents and social workers are trained in the Unit. This past summer a group of psychology students have had supervised field experience there. The amount of public education done by staff in their routine contacts with those indispensable community agencies and agents is difficult to evaluate, as is also the educational value of the alcoholic who has been helped by the Unit to take a responsible role in his society. Members of the staff are always available to address church and civic groups and high school classes in their region, and participate generously in the Department's seminars for clergymen, social workers, nurses, and other professional groups. Research, a major part of the original Spring Grove program, is still in the planning stage, still only a dream for the future.

Is the Crownsville program perfect, or even the best of all possible programs for alcoholics? By no means, and members of the staff are quick to point out its weaknesses and needs. They feel most desperately the need for addition of a clerk-typist to their ranks to facilitate communications with the outside world which cannot be handled by telephone, for more in-service training for new and old staff, and for opportunity to follow-up their patients and to evaluate the effectiveness of their work.

There is really no end to the story of an in-patient program to which as many as 165 alcoholics are admitted monthly, about half of them for the first time, but some concluding statement must be made to this report:

Alcoholism is a chronic, progressive, life-long disease, and no time-limited in-patient treatment program, no matter how good, no matter how devotedly adminstered, can be expected to manage it. The hospital can help the alcoholic get sober, and can help him choose to stay sober. Indeed, a recent statistical study indicates that 60% of the alcoholics admitted to Maryland State hospitals are not readmitted within two years. Nevertheless, much of the effort and dedication of staff working with alcoholic in-patients for short periods of time is tragically wasted unless other community resources are ready and willing to provide continuity of interest and caring and service to every alcoholic out-patient who looks for their help.

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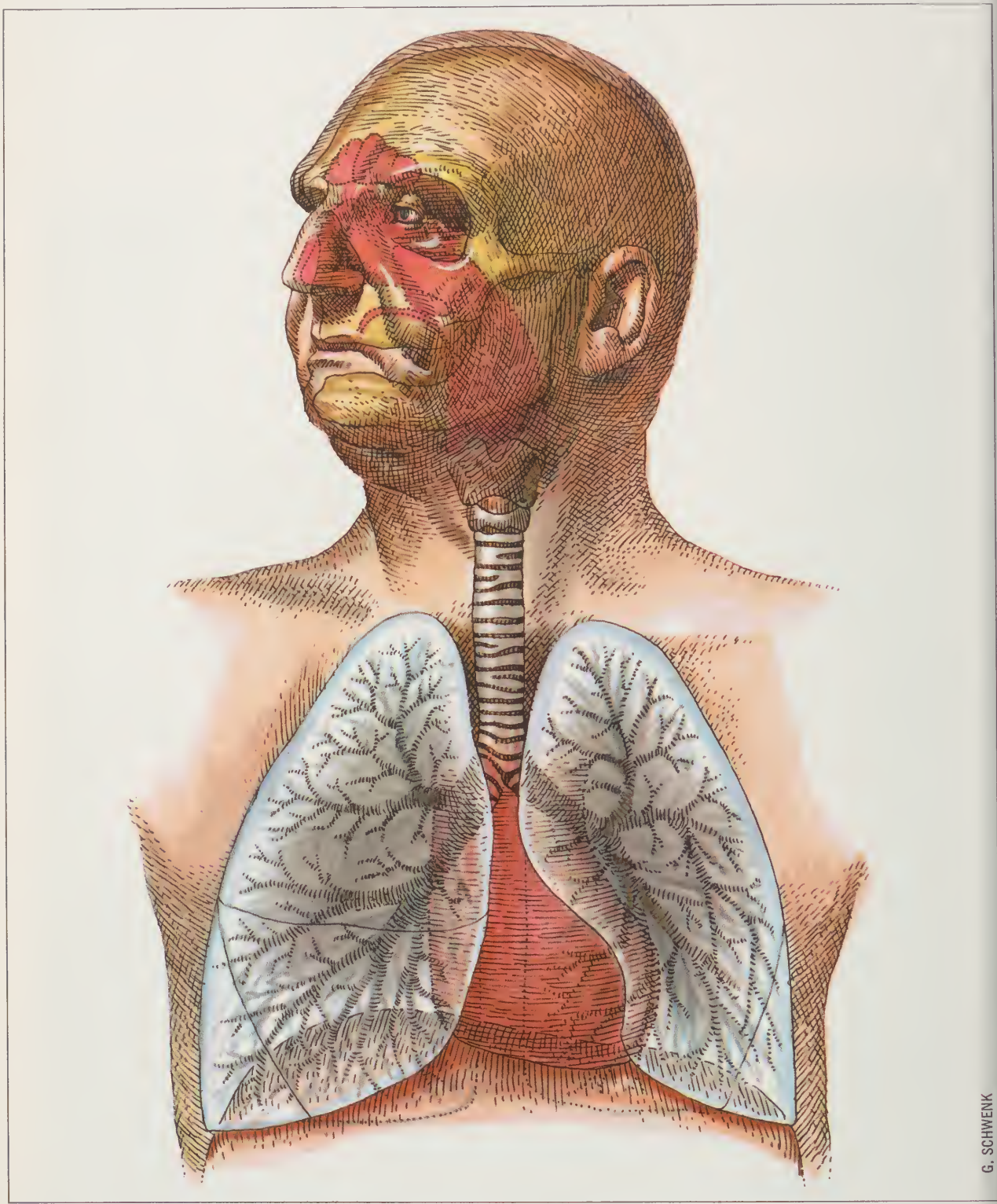
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this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



G. SCHWENK

Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

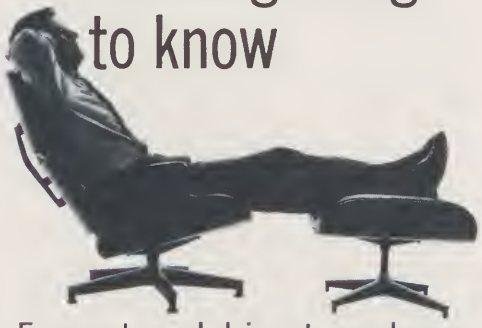
The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

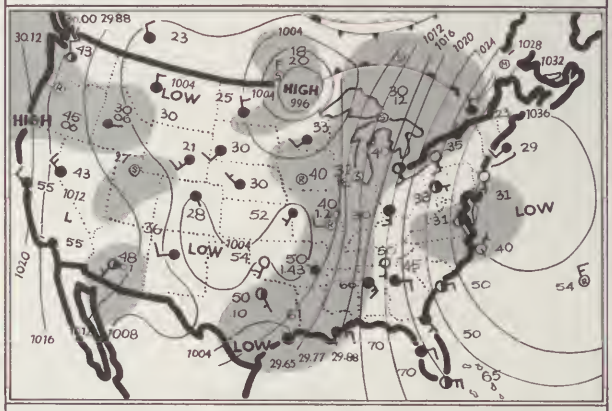
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

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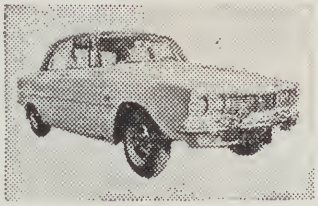
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Highlights

LABORATORY TRAINING GRANT RECEIVED

The Bureau of Laboratories has received a grant of $2,748 from the U.S. Department of Health, Education, and Welfare to conduct a five-day training program in "Advanced Tissue Culture Technique."

The course is to be directed by the assistant chief of the Bureau of Laboratories. Twenty health department workers and teaching personnel from a five state area are being selected to be trained in the new technique.

The Advanced Tissue Culture Technique was developed by Dr. Leonard Hayflick of the Wistar Institute, Philadelphia, who will be one of the featured speakers on the program. This technique is used to isolate such viruses as polio, rubella and influenza from clinical material and employs normal tissue rather than the abnormal tissue formerly used under the old technique.

APPLICATION FOR STRIP MINES DEMONSTRATION GRANT

The Department submitted an application to the U.S. Public Health Service for a grant of $126,318 to demonstrate the feasibility of utilizing abandoned strip mines in Western Maryland for the disposal of sewage sludge and solid waste material. If the grant is approved, the Department intends to conduct, in cooperation with Allegany County, a landfill operation in an abandoned strip mine to determine if these depressions can be used as depositories for solid wastes, to attempt to develop a method of eliminating these eyesores from Maryland's landscape, to restore the land to its natural state from the standpoint of erosion as well as beauty, and to determine if the filling in of these sinks with refuse will significantly reduce acid pollutants to the Potomac and Youghiogheny Rivers.

SEMINAR FOR MEDICAL AND DENTAL STUDENTS

The Department's 14th annual public health work-training program included ten-week project assignments for sixteen medical, four dental, and three nutrition students. Thirteen of the medical students were from the University of Maryland, two from Johns Hopkins and one from Yale. Three of the dental students were from the University of Maryland and one from Georgetown University. The nutrition students were from the University of Maryland, St. Joseph's College, Emmitsburg, and the Colorado Women's College in Denver. A list of the project report and copies of some of the papers are available upon request.

OCCUPATIONAL HEALTH INVESTIGATIONS

Due to a temperature inversion, a chlorine leak at a chemical plant caused respiratory distress among employees of a nearby plant in Cecil County. The lack of air movement caused by the inversion contained the chlorine gas in the narrow valley in which the neighboring plant is located. Because of either immediate or delayed reaction of employees to chlorine inhalation, the plant

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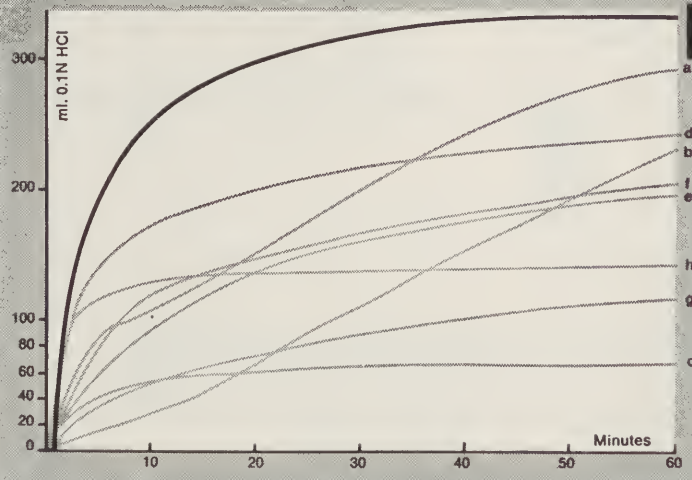
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*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

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was closed for two days. All those reporting any symptoms of exposure were sent to the medical center; 112 employees were examined; 4 required hospitalization; all are now reported to be in satisfactory condition. State and local health department personnel, in cooperation with the Department of Labor and Industry, worked together as a task force to prepare adequate engineering and medical recommendations to prevent the reoccurrence of such incidents. The Cecil County Health Department will conduct a continuing medical follow-up on those seriously affected.

At the request of the local health department, staff members investigated allegedly excessive exposures of employees to dust at an asphalt producing plant and at a ready-mix plant in Montgomery County. No excessive exposure was found.

An investigation of possible air contamination in a patient's home was made at the request of a private physician, without positive results. The Anne Arundel County Health Department is conducting a follow-up.

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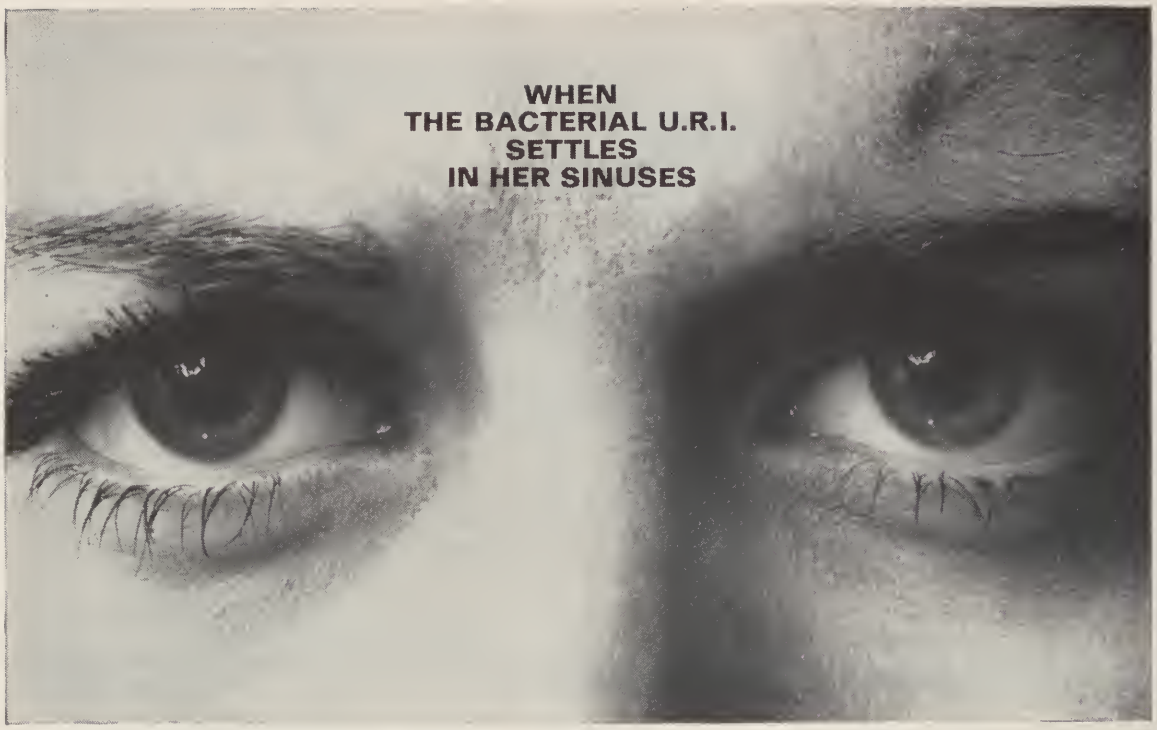
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Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals.

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Learn To Do Your Part In The Prevention Of Disease

New Comprehensive Health Services for Children and Youth

A plan to provide comprehensive health services, including dental care, for needy children and youth in economically deprived areas of Baltimore City was approved on May 16 by the Children's Bureau of the U.S. Department of Health, Education, and Welfare. Funded under the Social Security Amendments of 1965, PL 89-97, the new project, estimated to cost $2 million in the first year of a proposed five year period, will be administered by the Baltimore City Health Department.

An additional segment of the project, funded separately by the Children's Bureau in the amount of $1.2 million, will be under the direct purview of the Johns Hopkins Hospital, which will coordinate its part of the program with that of the Health Department.

Since the purpose of the grant is to increase the availability and improve the quality of health care services to children and youth, the program will be implemented by the establishment of Comprehensive Pediatric Care Centers administered in conjunction with existing Child Health Services. Each center will be staffed by new personnel employed by a local health center to conduct the program.

Identified as Project 606, this new Comprehensive Program for Children and Youth was designed by the City Health Department's Child Health Services under the direction of Dr. J. L. Rhyne. Hopefully, it will provide comprehensive and continuous care for approximately 40,000 needy children from infancy through secondary schooling, or age 18, and include medical, dental and psychiatric care. Baltimore City Hospitals, the Greater Baltimore Medical Center, the University of Maryland School of Medicine and Sinai Hospital have agreed to cooperate with the City Health Department in the development of the program. Project areas, and the number of children expected to be served in each, are as follows: Baltimore City Hospitals—5,000; Greater Baltimore Medical Center—2,000; Johns Hopkins Hospital—15,000; Sinai Hospital—5,000; and University Hospital—12,000.

Every effort will be made in the execution of this new program to cooperate with all private physicians and dentists in the areas served.

Dental Care

With tooth decay the most prevalent physical health problem of school age children, dentistry is an integral part of the service. Each center will contain appropriate dental facilities under the direction of a dentist with administrative and treatment responsibilities. His staff will include full and part-time clinicians, dental hygienists, and assistants according to need and clinic utilization. Close cooperation and consultations with non-dental members of the center staff to solve individual patient problems will be facilitated, as will access to special services and consultants anywhere in the community.

Administrative Staff

Administrative offices for the new project's staff members are located on the second floor of

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The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, the one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] It relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, vomiting and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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Precautions: Administer with caution in the presence of incipient glaucoma.
Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.
Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
References: 1. Jones, F. A., and Gummer, J. W. P.: Clinical gastroenterology, Springfield, Ill., Charles C Thomas, 1960, pp. 322-3. 2. Bockus, H. L.: Gastroenterology, 2nd ed., vol. I, Philadelphia, Saunders, 1963, p. 468. 3. Sun, D. C. H.: Ann NY Acad Sci 99:153 (Feb. 28) 1962. 4. Moore, V. A.: Postgrad Med 38:216 (Sept.) 1965. 5. Dragstedt, L. R., Woodward, E. R., Storer, E. H., Oberhelman, H. A., Jr., and Smith, C. A.: Ann Surg 132:626 (Oct.) 1950. 6. Posey, E. L., Jr., Smith, P., Turner, C., and Aldridge, J.: Amer J Dig Dis 10:399 (May) 1965. 7. Lamphier, T. A., Siegel, L., and Goldberg, R. I.: Amer J Gastroent 37:551 (May) 1962. 8. Kasich, A. M., and Fein, H. D.: Ibid 39:61 (Jan.) 1963. 9. Epstein, J. H.: Ibid 37:295 (Mar.) 1962. 10. Moeller, H. C.: Ann NY Acad Sci 99:158 (Feb. 28) 1962. 11. Slanger, A.: J New Drugs 2:215 (Jul.-Aug.) 1962. 12. Barman, M. L., and Larson, R. K.: Amer J Med Sci 246:325 (Sept.) 1963. 13. Shutkin, M. W.: Amer J Gastroent 38:682 (Dec.) 1962. 14. Fleshler, B.: J New Drugs 2:211 (Jul.-Aug.) 1962.

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The Alcoholic Patient

Last year, for the fifth consecutive year, more patients were admitted to Maryland's psychiatric hospitals for the treatment of alcoholism than for any other single diagnosis. More than two out of every five male admissions and one out of every eight female admissions were reported to be alcoholics. In addition, in excess of 10% of patients with other diagnoses were also reported to have a major drinking problem. Thus, alcoholism was related to the patient's illness in half of all admissions.

Alcoholism has been recognized as a serious community problem since the earliest days of recorded history. However, knowledge that alcoholism is a disease requiring both immediate and extended treatment is of recent origin. Court decisions during the past year have enforced this concept and will undoubtedly have a major impact on psychiatric treatment facilities. It continues to be one of the most important public health problems, both in the United States and in many other countries. While the total number of alcoholics is not known, it is estimated that at least 80,000 Maryland residents have a drinking problem sufficiently serious to interfere with their normal family relations and work habits. This figure would indicate that one family out of every ten has a member who is an alcoholic.

In recent years the number of alcoholic admissions has increased proportionally faster than other admissions. In 1960, 25.0% (1,161) of all admissions were diagnosed as alcoholics. This increased to 26.3% (1,330) in 1961; 28.6% (1,502) in 1962; 30.4% (2,188) in 1963; 31.2% (2,449) in 1964; and 32.7% (2,794) in 1965. Preliminary data for the 1966 fiscal year indicate a figure in excess of 3,200 admissions for alcoholism.

Alcoholic patients come from all parts of Maryland and from all socioeconomic and cultural strata. Statistical figures from last year's hospital admissions revealed: (1) 42% had elementary school education, 45% attended high school and 9% had some college training; (2) 65% were white males, 10% were white females, 21% were nonwhite males and 4% were nonwhite females: (3) 25% were Catholic, 70% were Protestant and 0.3% were Jewish; (4) 3% were less than 25 years old, 53% were between 25 and 44 years old, 41% were 45-64 years of age, and the remaining 3% were 65 years and older.

Although half of the alcoholic patients are self-admitted, many lack the motivation necessary for successful treatment. The unmotivated alcoholic poses a difficult challenge to the hospital staff. The problem of repeated hospitalization is higher than among other patients since successful treatment requires sustained abstinence, the development of constructive influences for continued sobriety, and the resolution of the underlying factors related to the alcoholism problem. To achieve this requires extended professional supportive services which, in many parts of Maryland, are woefully inadequate. The average length of hospitalization for the alcoholic is much shorter than for other patients. Hospitalization is just one phase of a range of programs needed to treat alcoholics. Recent data indicate that one-tenth are

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We need to know more about psychological, physiological and sociocultural factors influencing the incidence of alcoholism. Ultimate success depends on programs to minimize the occurrence of this disease and on early diagnosis and treatment of alcoholics. This requires the expansion and close coordination of psychiatric hospital and outpatient services, public agencies, community groups, and interested and informed individuals.

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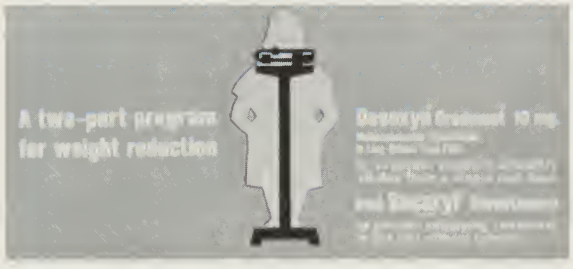
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If you are not convinced that the account is ready to be referred for collection, what are some of the systems used to encourage payment? What type of results can you expect from each?

Personal Letters.—They can bring excellent results. The trouble is that most are *too wordy* and lack the prime requisite of *being specific*. Such letters should review the entire account, ask if all is understood, and ask for a payment. You may wish to conclude with a request for an explanation or commitment if full or partial payment is not presently possible. The latter, however, often puts the patient on notice that you are open to "excuses."

EXAMPLE

Dear Mr. Grind:

Since August of 1965, I have rendered medical services to you, your wife, and family. Your account now stands at $189. I last received a payment (of $15) on December 3rd.

As far as I know, all fees have been understood. If not, I am willing to review each one.

Please pay all or at least a reasonable portion of your outstanding balance this week.

In the event full or partial payment is not possible, write or call in *an explanation of your tardiness, as well as an indication as to when I might expect your remittance.*

Sincerely yours,

Remember, be specific. Be positive. Let the patient be the expert in vague generalities.

Messages on Bills—If you have sent several bills with no response, should you include handwritten or typed notes on the next one? Generally, the messages used are "Please" or "Your early remittance will be appreciated."

If you want to use this approach, it might be better to say, "Please phone the office today, the doctor requires an explanation concerning this delinquent account."

Again, be positive.

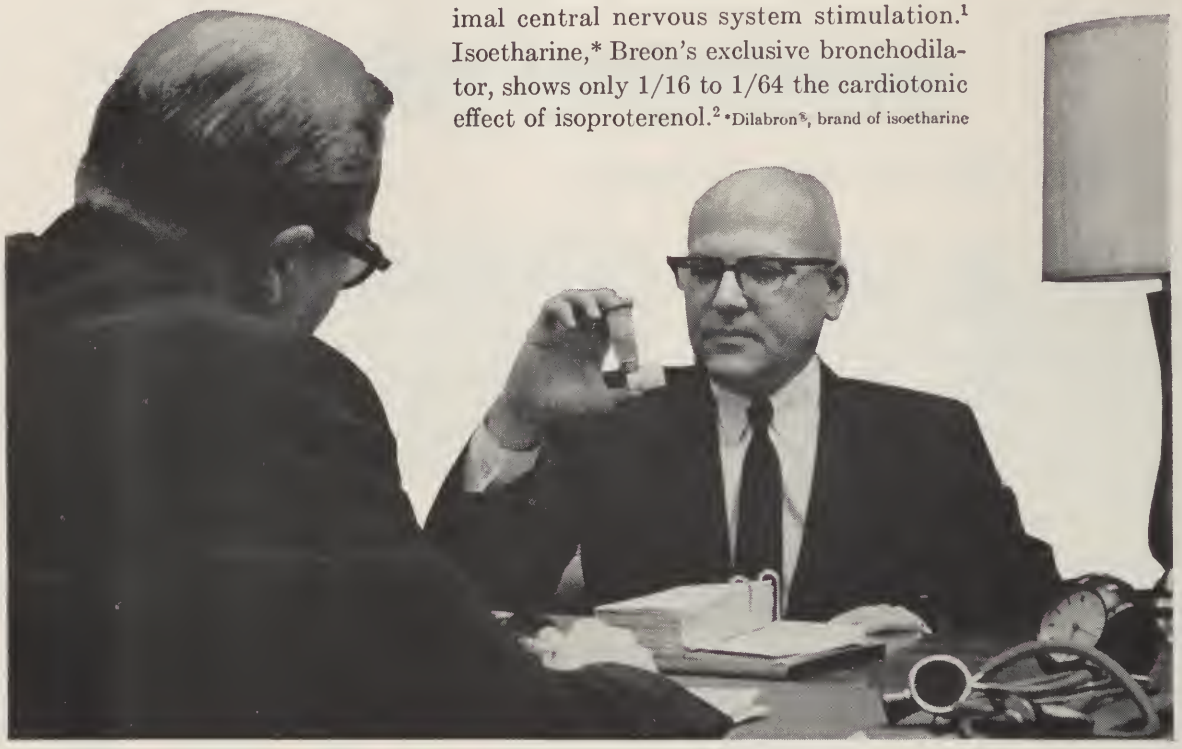
Stickers and Stamps—Success with such procedures as applying collection stickers or rubber stamp messages is almost nonexistent. They look unprofessional and appear as if you are not serious about putting your message across.

Telephone Calls—Some doctors use the phone to collect past due accounts. But for the most

Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

PRECAUTIONS: Bronkometer is unusually free from cardiovascular and other side effects, but the usual precautions associated with sympathomimetic amines should be observed. Bronkometer should not be administered simultaneously with epinephrine or similar compounds because of the possibility of tachycardia, although it may be alternated with these agents. Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve and in individuals sensitive to sympathomimetic amines.

SUPPLIED: 10 ml pressurized aerosol vials complete with measured dose valve and oral nebulizer.

References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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3. Immediately state the purpose for calling.
4. Record all responses.
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"Mr. Grind, this is Mrs. Mary Rush, Dr. Kermit Long's secretary."

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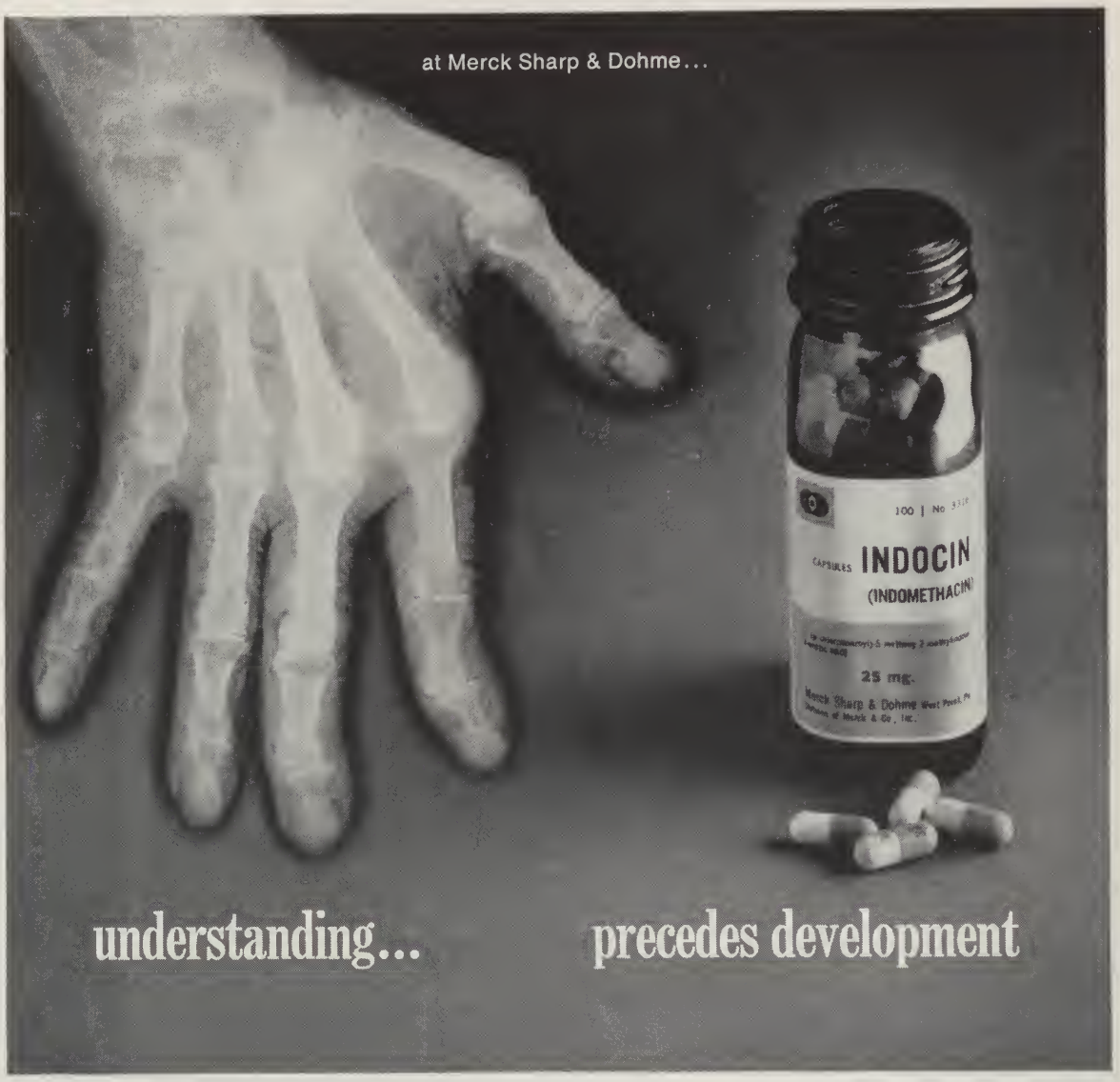
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Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
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AMA-ERF Fun(D) Day

November 10 is the date of the Woman's Auxiliary's annual FUN(D) DAY, held each year to raise money for the AMA Educational and Research Foundation. Each local auxiliary will sponsor a booth in Osler Hall, the Faculty Building, from 11:00 AM to 3:00 PM. The admission charge of one dollar will include lunch and a chance to win a door prize.

Mrs. Archie R. Cohen, president of the Auxiliary, and Mrs. Wallace H. Sadowsky, president-elect, are co-chairmen of the project. They urge every doctor's wife to participate.

Mental Health News

Mrs. Irving J. Taylor, who is Mental Health Committee chairman in the Woman's Auxiliaries to both the Medical and Chirurgical Faculty of the State of Maryland and the Baltimore City Medical Society, has announced a new project for the City Auxiliary's Mental Health Committee, in which all State Auxiliary members are invited to participate. A volunteer program for the Psychiatric Day Center in Baltimore City, this project has already won the support of almost 50 women, who have agreed to spend at least half a day during the year donating their services at the Center.

At the invitation of Gertrude Gross, MD, director of the Center, fourteen of these women attended a meeting there and were taken on a tour of the facilities. Mrs. Taylor reports that they were all very much impressed with the work being done, and that a registered nurse and a dentist, who joined the group for the tour, volunteered their services "on the spot." She stresses the fact, however, that many more volunteers are needed.

As a tie-in with this new mental health program, Albert A. Kurland, MD, spoke on "LSD in Experimental Psychotherapy" at the first meeting of the City Auxiliary on October 12. Mrs. Taylor's future plans include a seminar on the subject of suicide, and visits to psychiatric facilities in the area.

Montgomery County

The Auxiliary to the Montgomery County Medical Society held its first luncheon and business meeting of the season at the Linden Hill Restaurant in Bethesda on September 20. Mrs. Norman Oliver and Mrs. William D. Aud were co-chairmen of the luncheon.

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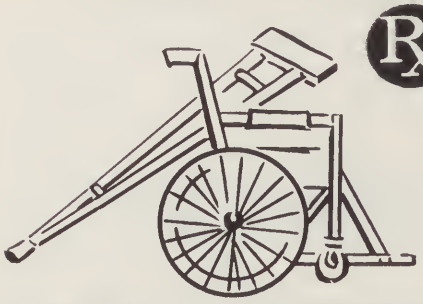
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GRANTS-IN-AID: To support an investigator's research project in a qualified non-profit institution in Maryland. Term: 1-2 years beginning July, 1967. Awards: Maximum $6000. Application deadline: December 1, 1966.

VISITING SCIENTIST PROGRAM: To bring outstanding research scientists to Maryland to lecture, consult with young investigators, and hold seminars in the field of cardiovascular research. Term: 3-5 days beginning January 1, 1967. Stipend: All expenses plus honorarium dependent on durotion. Deadline for nominations: November 15, 1966. Nominations must be made by a Maryland host scientist.

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Book Reviews

THE NEUROENDOCRINE CONTROL OF ADAPTATION, by K. Lissák and E. Endröczi, Pergamon Press, 1965. $11

This book contains a comprehensive and critical account of the way in which the central nervous system controls those endocrines concerned with the adaptation of an animal to its environment.

LEXICON ALLERGOLOGICUM, edited by Knud Wilken-Jensen, Pergamon Press, 1966. $5

Published under the auspices of the European Academy of Allergology, this is a six-language dictionary of allergological terms. It contains terminology, explanation of the terminology, and a list of the most common allergens. The languages are English, German, French, Italian, Russian, and Spanish.

MEDICAL CARE RESEARCH, edited by Kerr L. White, MD, Pergamon Press, 1966. $7.50

This book contains the proceedings of a symposium on Medical Care Research. The collection of articles has been published in the *Journal of Chronic Diseases*, Vol. 17, 1964.

The symposium represents current problems and methods in the field as found in the United States and Great Britain. The papers have been selected to illustrate research primarily concerned with personal health services provided by physicians and nurses, either in offices and clinics or in hospitals and nursing homes.

References accompanying the papers give a comprehensive guide to the literature in this field.

PATHOLOGY, vols 1 and 2, ed 5, edited by W. A. D. Anderson, MD, C. V. Mosby Co., 1966. $21

This edition retains the original objective to provide a comprehensive, thorough, and balanced coverage of pathology. It is intended as a reference for the medical student and the physician in clinical practice. Changes and additions have been made as necessitated by new knowledge.

DISEASES OF THE HEART, ed 3, by Charles K. Friedberg, MD, W. B. Saunders, 1966.

This edition represents extensive revisions and additions. The chapters were updated right up until press time to include current investigation still in press or being prepared for publication. The newer diagnostic methods have been discussed extensively, and therapeutic advances are presented in detail.

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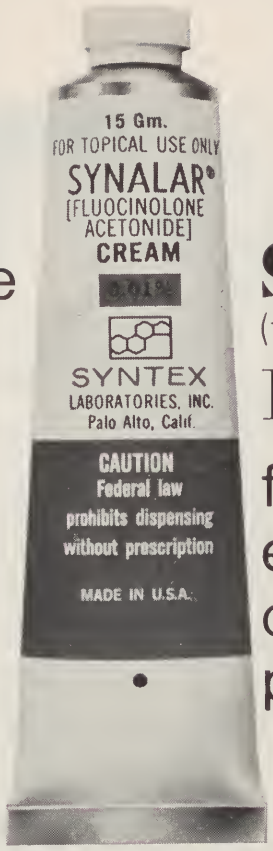
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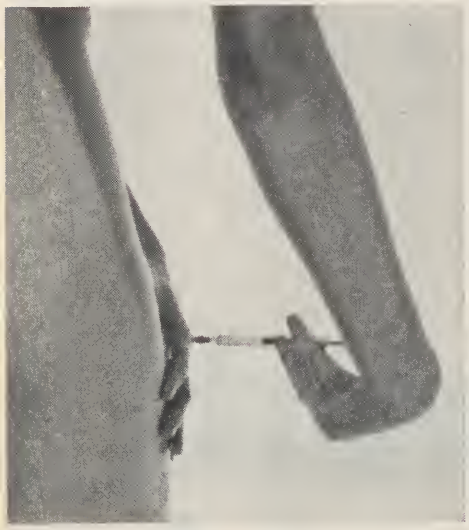
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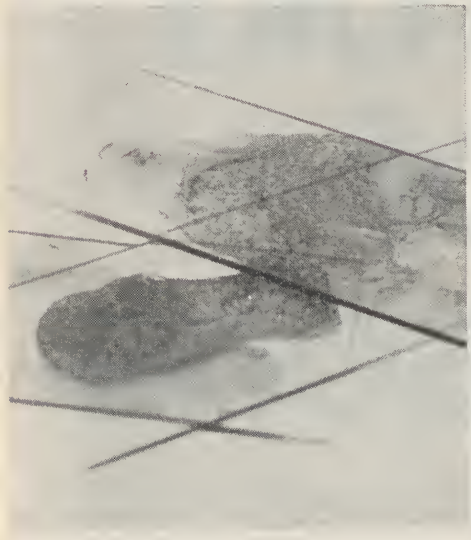
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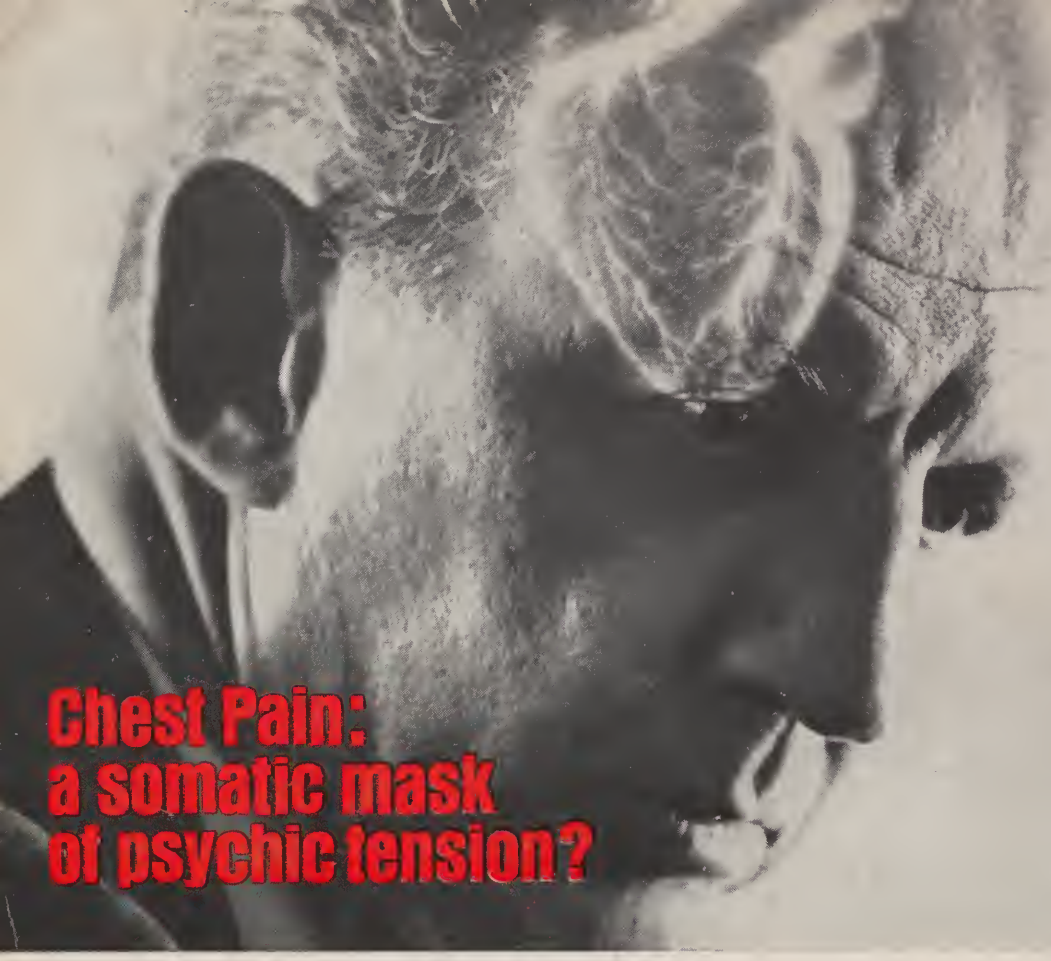
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Maryland
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MEDIC

FRIDAY POSTGRADUATE PROGRAMS

(See page 175 for list of locations where MEDIC programs may be heard)

November 25—1 PM

Intersex Problems

Milton S. Grossman, MD, assistant professor of pediatrics, University of Maryland School of Medicine.

December 2—12:30 PM

Treatment of the Female Climacteric

Arthur L. Haskins, MD, professor and head of the department of Obstetrics and Gynecology, University of Maryland School of Medicine.

December 9—12:30 PM

Peptic Ulcer

Theodore M. Bayless, MD, instructor of medicine, The Johns Hopkins University School of Medicine

and

Walter F. Ballinger, II, MD, associate professor of surgery, The Johns Hopkins University School of Medicine.

December 16—12:30 PM

Kidney Disease

Warren P. Gruppee, MD, Babies and Children's Hospital, Cleveland.

January 6—12:30 PM

Use of Drugs and Alcohol and Their Relation to Automobile Accidents

Russell S. Fisher, MD, professor of forensic pathology, University of Maryland School of Medicine

and

Henry C. Freimuth, MD, associate professor of forensic pathology, University of Maryland School of Medicine.

January 13—12:30 PM

Arteriosclerosis and Diet

Benjamin M. Baker, MD, professar of medicine, The Johns Hopkins University School of Medicine.

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2:30 PM-4:30 PM
November 29, 2:30 PM-4:30 PM
November 30, 10:00 AM-12:00 NOON
December 1, 10:00 AM-12:00 NOON
December 2, 10:00 AM-4:00 PM

The public is invited to the last program.

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December 6, 5:30 PM

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December 8

Psychiatric Treatment for College Students

Dana L. Farnsworth, MD, professor of psychiatry, Harvard Medical School.

Dinner Meeting—The Seton Institute

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December 2, 7:30 PM

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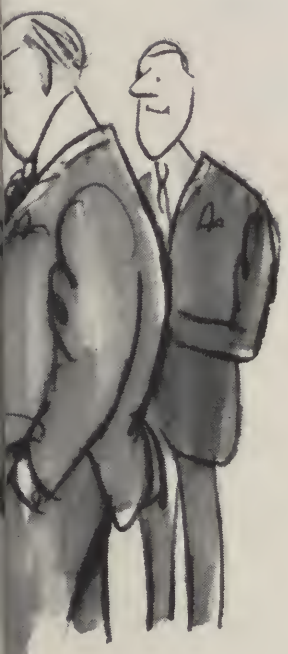
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Milford O. Rouse, MD, president-elect, American Medical Association
James F. Holland, MD, chief of medicine, Roswell Park Memorial Institute
Walter L. Henry, MD, professor of medicine, Howard University
Richard E. Palmer, MD, professor of pathology, George Washington University School of Medicine
Edgar S. Gordon, MD, professor of medicine, University of Wisconsin Medical Center
Michael E. De Bakey, MD, professor of surgery, Baylor University College of Medicine

In addition, there will be a kidney symposium covering the subjects of chronic dialysis, transplantation, bacteria urea and urinary tract infections, and glomerulonephritis.

To keep the physicians of Maryland abreast of scientific advancement, there will be many technical and scientific exhibits. Any member of the Faculty, who has a scientific exhibit he would like to display, should contact the Committee. All exhibits accepted will be eligible for the $200 award to be presented by the Mead Johnson Company for the most outstanding scientific exhibit. The Faculty Committee will judge the exhibits.

The always popular and well attended Round Table Luncheon has been scheduled at the "One West" restaurant on Wednesday, April 19. On Thursday, April 20, at the Sheraton-Belvedere Hotel, the annual Presidential Dinner (with the best of professional entertainment) will be held. The House of Delegates of the Faculty will meet on April 19 at the Alcazar and on April 21 in the Faculty Building.

NOTE THESE DATES NOW

APRIL 19, 20, 21, 1967

Committee on Program and Arrangements
James B. Brooks, MD, Chairman

Your MEDICAL FACULTY at Work

JOHN SARGEANT — EXECUTIVE SECRETARY

House of Delegates, September 9

1. Two amendments to the Medicolegal Code of Cooperation were adopted, the first related to reports of an attending physician to a patient or his attorney, the second to referrals of a patient by attorneys to another physician without the knowledge of the treating physician.

2. The Building Committee was dissolved by unanimous vote and the funds under its control transferred to separate Building Fund accounts.

3. The House rejected a resolution which would have instructed the Legislative Committee to propose a bill to the State Legislature amending the Medical Practice Act to allow certain corporate practice.

4. It was resolved that the Faculty's Liaison Committee review the numerous requisition forms of various departments, companies and agencies, and hold hearings where physicians could voice their grievances, with a view to eliminating as much cumbersome paper work as possible.

5. The House rejected a resolution to the effect that the Faculty use its offices to persuade the State Commissioner of Health to rescind his directive excluding the practicing physician's screening activity from the benefits of the Maryland State Department of Health Laboratory Services.

6. A resolution was adopted to urge the Maryland Blue Shield Plan to develop a program covering professional fees based on reasonable and customary charges and to bend every effort toward the substitution of the new program for the present fee schedule program.

7. It was resolved that the Faculty, with the Maryland State Department of Health, should immediately develop a health care program for the disadvantaged (under the provisions of Title XIX of Public Law 89-97) providing for all payments for professional services on the basis of usual, customary and reasonable charges; that all physicians should be urged henceforth to *bill* on this basis (despite the fact that *payments* must presently be made on the basis of budgeted funds) in order to demonstrate the extent to which physicians are now subsidizing the Medical Care Program; and that copies of the resolution be sent to various key State officials.

8. The House went on record as urging its members to bill on the basis of usual, customary and reasonable fees for professional services rendered Workmen's Compensation Cases as well as other government cases.

9. The House also went on record as opposing the compulsory assessment of hospital staff members for hospital construction or equipment.

10. The MEDIC network for the 1967 calendar year was approved.

Executive Committee, October 6

1. Subject to his right of appeal as provided in the Faculty Bylaws, and subject to approval of legal counsel, the six-month suspension of membership of Leonard Flax, MD, was voted to take effect 30 days after receipt of disposition of his

*See pages 82-99 for full text of minutes and reports.



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case by him. (Dr. Flax has appealed this decision to the Judicial Council of the American Medical Association.)

2. On the recommendation of the Treasurer, an expenditure of $2,000 was voted for roof repairs as part of the Faculty's continuing renovation program.

3. The Committee authorized the expenditure of up to $100 for AMA pamphlets on "Alcoholism" for distribution by Component Societies to schools in the area.

4. The Committee reviewed a list of appointments to various AMA councils, committees and boards scheduled for the consideration of the AMA Board of Trustees and, except for non-members of the Faculty or AMA, voted approval of the list.

5. Donald E. Fisher, MD, and B. Martin Middleton, MD, were selected as Faculty representatives to the Congress on Socioeconomics of Health Care, to attend at AMA expense.

6. The Committee voted for an expression of appreciation to A. Gibson Packard, MD, for the time he spent as Faculty representative to a meeting on Vocational Rehabilitation.

7. The following recommendations to the Motor Vehicles Commissioner for appointment to the Department's Medical Advisory Board were approved: A. H. Oleynick, MD; Frank F. Schuster, MD; and Edward F. Wenzlaff, MD, all of Baltimore.

8. The Committee voted approval of the content of a pamphlet on laws, rules and regulations with which physicians must comply, the pamphlet having already been cleared by the State Health Department, legal counsel and others. The estimated cost of printing 5,000 copies will be obtained.

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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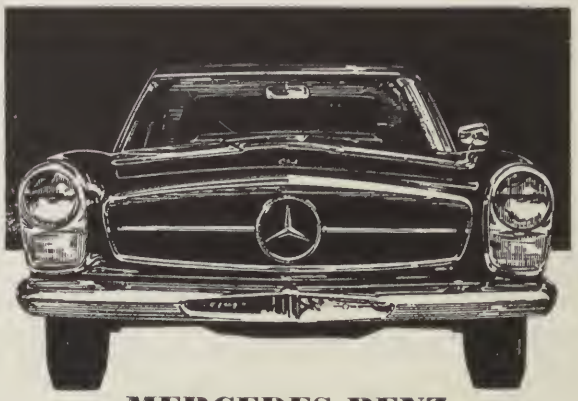


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EXECUTIVE SECRETARY'S NEWSLETTER

November, 1966

DEPENDENTS' MEDICAL CARE CHANGES

Changes in the Dependents' Medical Care program have been made known by the U. S. Government. Basically, they provide for payment of out-patient services, on the basis of a $50.00 per person or $100.00 per family deductible program, plus payment by the government of 80% of the balance due. Full details will be contained in a bulletin distributed to all physicians by Maryland Medical Service, fiscal agents for this program.

ANNUAL MEETING RESOLUTIONS

Resolutions for consideration at the Faculty's Annual Meeting should be received in the Faculty office by:

WEDNESDAY, FEBRUARY 22, 1967

No date has been set for the Reference Committee hearing as yet, but a general notice will appear as soon as it is scheduled.

PHYSICIAN REMINDERS

Physicians are reminded they are required to report suspected cases of Child Abuse to the local Welfare Department within 24 hours of them coming to their attention. Penalties are in the law for failure to comply.

Physicians are also reminded that the police continue to report sample drugs are being retrieved from trash cans and being used for illegal purposes. Once again, this important point is brought to the attention of all those concerned for corrective action. Do any of your secretaries do this without your knowledge?

MEDICAL ASPECTS OF SPORTS

One of the Faculty's newest Subcommittees is on the Medical Aspects of Sports; and is interested in comments, suggestions and questions on activities in which it can engage. The first meeting of this group was held in October. Chairman is John B. DeHoff, M.D., Baltimore. The Subcommittee is, initially, involving itself in elementary and high school athletic programs.

NEWS NOTES

William B. Vandegrift, M.D., F.A.C.P., has opened offices for the practice of diagnostic cytology and tissue pathology in Ruxton, Md.

Thomas L. Worsley, M.D., has removed his office to 6505 York Road, Baltimore.

Francis T. Daly, M.D., Baltimore, is now certified by the American Board of Internal Medicine.

The Third National Conference on Work Evaluation Units, sponsored by the Heart Association of Maryland, will hear Drs. Francis J. Borges and Donald H. Dembo, as panelists on "As Team Members See Themselves in WEU Operations."

Nathan W. Shock, M.D., Bethesda, has been named President-elect of the International Association for Gerontology.

Jacob H. Conn, M.D., Baltimore, presented the Adolf Meyer lecture at the 18th annual meeting of The Society for Clinical and Experimental Hypnosis in New York City.

WORK LABOR PERMITS

In order to further clarify the question of completion of Work Labor Permits for minors, the following advice is provided:

1. The "application" for Work Labor Permit may be completed by any physician. Charge for this examination and completion is paid by the patient.
2. The "Permit" itself is <u>issued</u> by Authorized Physicians only. The medical statement on this permit is not completed if the physician did not examine the minor.
3. The "Permit" need not be issued by a local or Authorized Physician, but the "Application" may be mailed to the Baltimore office of the Department of Labor and Industry for issuance of the "<u>Permit</u>" without further charge.

John Sargeant
Executive Secretary

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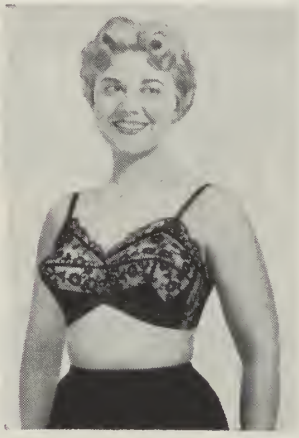
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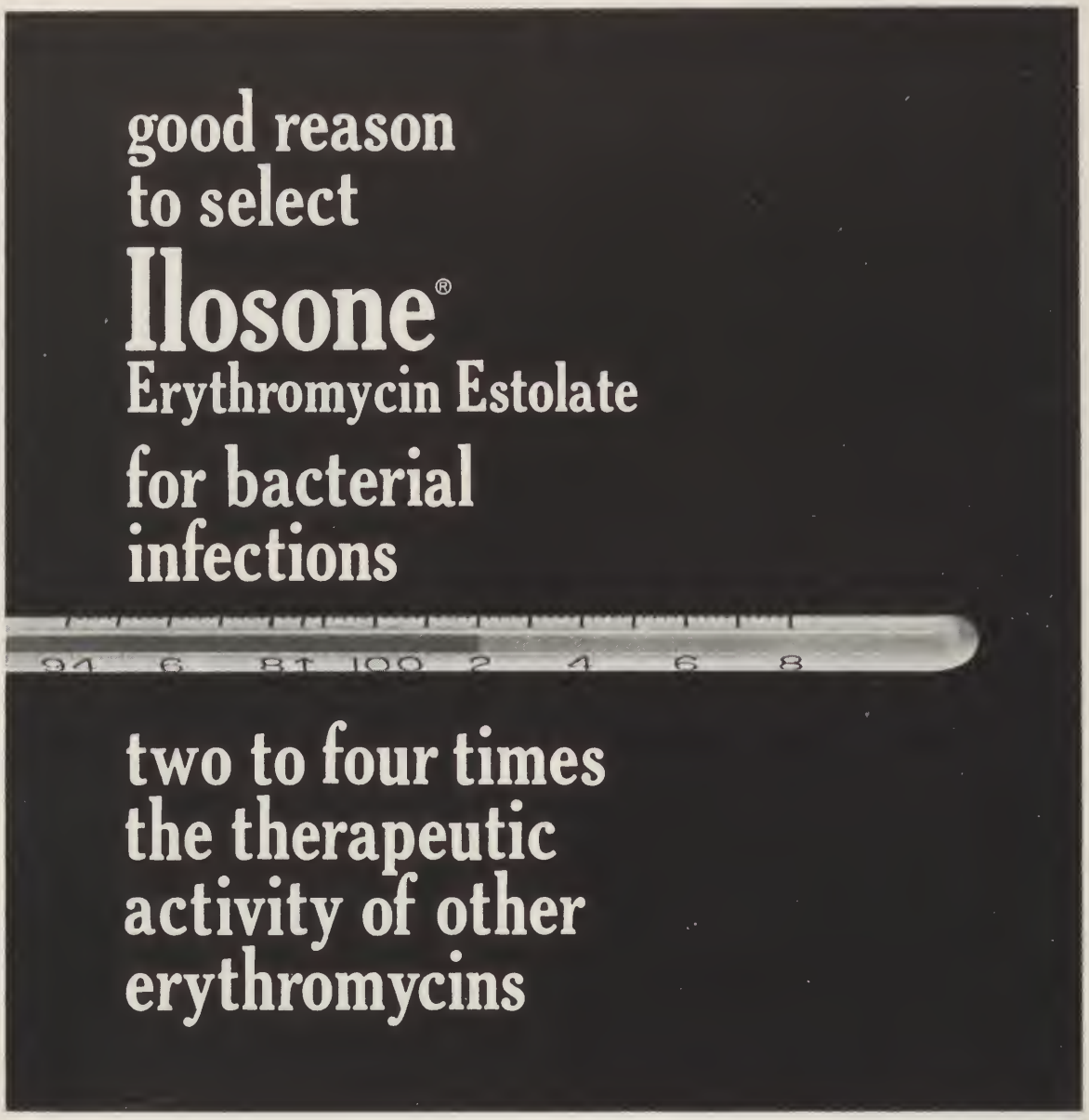
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CONTRAINDICATIONS: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

SIDE-EFFECTS: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

DOSAGE: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

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Maryland State Medical Journal
Vol. 15, No. 11
November, 1966

URINARY STASIS AND URINARY INFECTIONS IN GYNECOLOGICAL AND OBSTETRICAL PATIENTS

HOUSTON S. EVERETT, MD
Associate Professor of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine

Most urinary infections are associated with urinary stasis. The causes of urinary stasis in women are different from those usually found in men, and are most frequently associated with pregnancy or with gynecological diseases or therapy. Complete retention often occurs after gynecological surgery, especially operations on the anterior vaginal wall. The gynecologic causes of stasis are listed and illustrated.

Last year at our annual meeting Dr. Theodore Fetter, of Philadelphia, made the following statement: "A vast body of experimental and clinical evidence emphasizes and reinforces the well-established principles that urinary infection usually means an obstruction is present."

Except for the type of infection represented by a simple acute cystitis in female patients, which occurs often and is a spontaneous entity, I agree most heartily with this statement.

I just as heartily disagree with those internists and pathologists who have condemned the catheter as a practically lethal weapon and have assumed or postulated the diagnosis of pyelonephritis on the finding of 100,000 or more colonies of pathogenic organisms per cubic centimeter in so-called "clean catch" cultures of urine. A clean catch specimen and culture in female patients, if negative, is probably accurate; but in many women with leukorrhea, from one cause or another, it is impossible to obtain an uncontaminated specimen. Such specimens, if positive, are therefore apt to be unreliable and do not justify the positive diagnosis of any type of urinary tract infection unless confirmed by a culture of a catheterized specimen.

In an article in the January 17, 1966 issue of *The Journal of The American Medical Association,* Dr. Edward N. Cook, of the Mayo Clinic's Section of Urology, thoroughly debunked these fallacious ideas in a most delightful way.

J. Mason Hundley Annual Lecture in Gynecology, presented at the 168th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, April 27, 1966.

Assuming then, with Dr. Fetter, that most serious urinary tract infections are associated with obstructions, let us discuss the causes of obstruction in female patients. These often differ markedly from those found in the male and are frequently the result of gynecologic disease or therapy.

It has been known for many years that carcinoma of the cervix, when untreated or uncontrolled, eventually produces uteral obstructions. Figure 1 is an illustration of an autopsy specimen from Dr. Howard A. Kelly's *Operative Gynecology,* published in 1898, and shows a complete ureteral obstruction as a result of invasion of the broad ligament regions by the carcinoma.

My interest in this subject was first aroused during my resident year at the Johns Hopkins Hospital in 1929, when a patient who had been treated for Stage III carcinoma of the cervix by irradiation therapy 18 months before, came into the hospital with a large vesicovaginal fistula and ascites, which Dr. Guy Hunner and I were almost certain was urinary ascites (Fig 2).

This patient was already uremic and moribund, but we did attempt to relieve her obstruction by

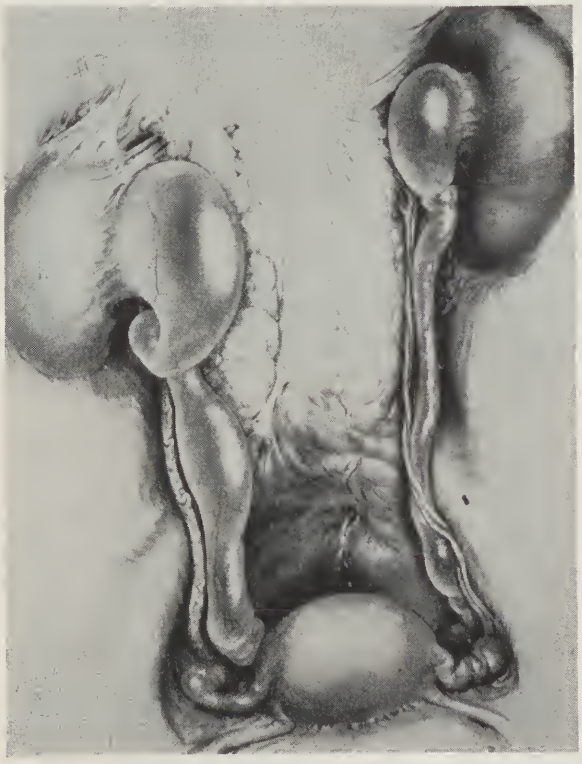


Fig 1

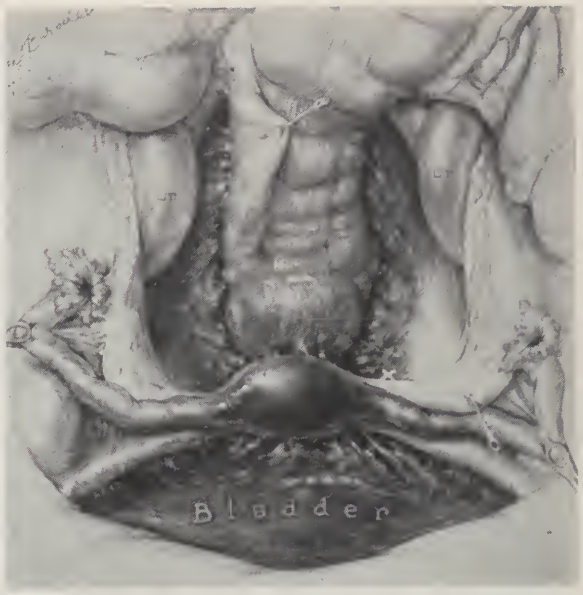


Fig 2

operation and transplantation of the markedly dilated ureters. We found that the ascites was, indeed, urinary ascites, as the left ureter was perforated at the point indicated by a white cross in Figure 2. The operation was unsuccessful. The patient died within a week. Figure 3 shows one of her kidneys, which demonstrates very well why she did. They were both just alike, but the interesting thing to me was that a very thorough autopsy revealed no remaining carcinoma.

So this patient had died as a result of having had carcinoma, but she did not die from the carcinoma. She died from the ill effects on normal tissues of the intensive radiation which was the method of treatment in those days. We had no irradiation clinic at Hopkins. We referred our patients to the Howard A. Kelly Hospital, where they were treated on an outpatient basis with a very rapid method and a relatively small dose in terms of milligram hours, of radium—only 3,000. They were treated awake. They could not be thoroughly packed, and this rapid method of irradiation had destructive effects on the normal tissues in many cases.

This case led me to undertake a study which I reported, ten years later in 1939. We studied our carcinoma of the cervix cases, both before treatment and at varying intervals after treatment. All



Fig 3

of these patients were treated by this rapid method, and about 15%-20% developed serious bladder lesions and obstructive lesions of the ureters. We also found that if pretreatment studies showed any evidence of obstruction, the prognosis was poor. This is demonstrated in Table 1. There was no dilatation in Stages I and II, but of 28 patients in Stage III there were 16 with pre-treatment dilatation and 12 without it. All 16 died in less than a year and 75% of the 12 survived five years.

Table 1

PROGNOSTIC VALUE OF URETERAL DILATATION STAGE III CARCINOMA OF CERVIX

Number of Patients	Five-year Result
16 with dilatation	All dead
12 without dilatation	75% well

We have continued these studies and now the method of irradiation is very different. Larger doses are given, usually 4,800 mgm hours of radium followed by cobalt therapy, but the radium is administered in two applications of 100 mgm for 24 hours two weeks apart. With this slower method of treatment, ill effects have been reduced from 15%-20% to about 1%.

These studies aroused my interest in the effects on the urinary tract of various gynecologic lesions and methods of treatment which we have carried out over the years, and we have arrived at a concept of the causes of obstruction in female patients.

Figure 4 shows the close relationship of the lower ureter to the genital organs. The ureter comes down following the ovarian vessels and, in the base of the broad ligament, passes behind the uterine vessels. It is close to the cervix and can



Fig 4

easily be injured during total hysterectomy if one is not careful. Any growth, such as an intraligamentous fibroid, tends to impinge upon the ureter.

Table 2 shows my idea of the causes of urinary stasis in female patients. In the male patient, the causes of stasis are more likely to be in the lower urinary tract, in the urethra, or in the vesical neck. The causes of stasis in this region in female patients are relatively rare. In this table, the underlined headings are the ones that I consider of gynecologic or obstetric interest. The others are of purely urologic interest.

Most of these conditions are rare, but postoperative retention is one which we encounter very frequently in gynecology and one which, in the last five or six years, has given rise to a great deal of discussion, and to the condemnation of the use of the catheter. The internists and pathologists who have promulgated these ideas, however, have had no actual experience with urologic problems. Their ideas have come from autopsy studies of patients who died from chronic pyelonephritis, most of whom had asymptomatic pyelonephritis and therefore never had treatment of any kind, either urologic, which should be the elimination of obstructive lesions, or medical, which should be the use of the proper medicinal agents to eradicate infection.

In my earlier days most patients having had gynecologic operations had difficulty voiding. They either had to be catheterized intermittently or have retention catheters. Now, with early ambulation, that is no longer true except for the patients who have vaginal plastic operations, particularly those on the anterior vaginal wall. But a very large percentage of those patients cannot void following operation. The operative field becomes edematous, the urethra is closed off by compression from this edema, and it is essential that the bladder be drained.

A great deal of, shall I say, gadgetry has been proposed in the last five or six years to try to manage this situation without inducing an infection. In the use of an inlying catheter, particularly in the female and regardless of how the catheter is drained, the catheter slides in and out and these patients all get infected. But these infections are bladder infections. They are not serious. They do

Table 2
URINARY TRACT OBSTRUCTION OR URINARY STASIS

I. At level of urethra or vesical neck
  A. Urinary retention
    1. Postoperative
    2. Postpartum
    3. From obstructive lesions in urethra or vesical neck
      a. Urethral stricture
      b. Fibrosis or contracture of vesical neck
      c. Suburethral cyst or abscess
    4. From external compression
      a. Pelvic abscess
      b. Submucous myomas protruding into vagina
      c. Exaggerated retroversion of enlarged uterus
      d. Complete procidentia
      e. Hematocolpos in young girls with imperforate hymen
    5. On psychogenic basis
    6. On neurogenic basis
  B. Residual urine
    1. From all of above causes in lesser degree
    2. Cystocele
II. At ureteral and renal level
  A. Physiologic hydroureteronephrosis of pregnancy
  B. Hydroureteronephrosis from gynecologic causes
    1. Pelvic masses
      a. Uterine myomas
      b. Ovarian cysts
      c. Inflammatory masses
      d. Endometriosis
    2. Uterine prolapse
    3. Genital malignancy
      a. Carcinoma of cervix
      b. Irradiation therapy
      c. Surgical injury
      d. Carcinoma of ovary
  C. Intrinsic ureteral lesions
    1. Ureteral stricture acquired
    2. Ureteral stricture congenital
    3. Urethral valves and diverticula
  D. Extragenital extraneous ureteral obstructions
    1. Nephroptosis with ureteral kinks
    2. Aberrant renal vessels

not lead to pyelonephritis.

To study just this matter, in the past year and a quarter Dr. Herman Long and I have obtained catheterized cultures of urine on all of our patients subjected to repairs with inlying catheters, at their first postoperative visit—usually about six weeks after discharge. There have been 25 of these patients and only one of them had a positive culture. That positive culture was in a patient who developed such a severe febrile and urticarial reaction to the sulfonamide therapy instituted for her immediate infection that it had to be discontinued within a day or two after it was started.

These patients all had infection. We used to use prophylactic drugs, but we found this didn't work. It didn't keep them from getting infected and it sometimes led to the development of drug resistant organisms. So now we obtain a culture immediately before removal of the catheter, we have sensitivity studies run on the organism obtained, and we use the drug indicated by these studies for ten days. I think the result of 24 out of 25 patients with sterile cultures at the first follow-up visit indicates that this is an entirely satisfactory procedure without all the gadgetry that has been recommended.

In an article by Dr. C. E. Cox and Dr. Frank Hinman, Jr., in the January 18, 1965 issue of *The Journal of The American Medical Association,* it was shown that in an experimental group of 80 males with normal bladders, inlying catheter-induced infections all cleared up within a few days to a few weeks after removal of the catheter, without any therapy at all. They concluded that it is hard to infect, or to maintain infection in, the normal bladder due to two things, the washing out of the bladder by normal voiding and an antibacterial effect within the bladder tissues.

Of course these gynecologic patients do not have normal bladders when the catheter is inserted. The bladder has not been subjected to actual internal trauma, but there has been trauma all around it in the dissection of the bladder and the urethra, and the urethra is, for the time being, closed off. But the bladder is very quickly returned to normal, infections clear up, and in my mind all of this business has been making a mountain out of a molehill.

Here is one situation in which we do have frequent trouble. This does not involve an actual inability to void, but occurs in patients with large cystoceles who have residual urine because a portion of the bladder is below the level of the outlet of the bladder and tends to get infected. It sometimes is infected when the patient comes in and, if the operation is to be done, an attempt should be made to clear up that infection beforehand.

If we go on to the upper level (Table 2, II), we find a great many more causes of obstruction and stasis than we do at the lower level of the female. The most frequent one of these is the so-called physiological hydronephrosis of pregnancy, which occurs in practically 100% of pregnancies. This has given rise to a tremendous literature because when this infection occurred before the days of the present drugs, it was a very serious problem. It often led to the necessity of inlying catheters in the ureters and sometimes to the termination of pregnancy. That is no longer true but, meanwhile, in this volume of literature there were two schools of thought.

One was that the causation of this was mechanical, that is, that the ureters were compressed by the enlarged pregnant uterus; the other was that the causation was hormonal—in other words, that the ureteral peristalsis was inhibited both as to strength and frequency by the presence of some hormone.

Incidentally, Dr. Herbert Traut, who at that time was at the New York Hospital at Cornell, studied this peristaltic activity and he assumed that progesterone was the hormone involved. And Dr. Hundley, who made a similar study on nonpregnant women using large doses of both estrogens and progesterone, found that the estrogens increased the peristaltic activity and the progesterone inhibited it. I mention this mainly because of Dr. Hundley's interest in it. I do not consider it very important because I belong to the mechanical school.

All of these other things give rise to stasis quite frequently—in 65% of uterine myomas, in 80% of ovarian cysts and so on. We've already talked about carcinoma of the cervix and irradiation therapy. Radical operation for carcinoma of the cervix originated many years ago. Dr. Ernst Wertheim is given credit, but actually three people—Dr. John Clark, who at that time was at Johns

A Key Site of Action of the Protoveratrine A in Salutensin

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Hopkins and later went to Philadelphia and two other doctors, one named David Meredith Reese and one named Theodor Rumpf, did this operation before Wertheim and Wertheim gave them full credit.

But in those days Wertheim himself found 49 ureteral injuries in his first 500 cases, or 10%. Approximately the same figure, between 9% and 10%, was reported a few years ago by Dr. Joe Meigs and one of his associates from Boston.

Ureteral stricture, acquired, I put in because I think some of these gynecologic lesions cause



Fig 5

these acquired strictures. And I put in nephroptosis because that occurs about five times as frequently in females as it does in males, probably because of the great change in fat distribution associated with pregnancy and the termination of pregnancy.

Now we'll go along to some illustrations of some of these conditions. Figure 5 shows a typical hydro-ureteronephrosis of pregnancy. Here we see that it is greater on the right side than it is on the left, which is perfectly typical, and that the dilatation stops at the pelvic brim, the point at which the ureters would be compressed by the



Fig 6

pregnant uterus. That is the reason I feel the mechanical factor is the more important one.

In Figure 6 is a seventeen-year-old girl with an ovarian cyst. The dilatation is very similar to that



Fig 7



Fig 8

of pregnancy dilatation and of course an ovarian cyst is very much the same consistency as a pregnancy.



Fig 9

In Figure 7 you see a patient with a myomatous uterus as large as a term pregnancy. You can see the large soft tissue shadow. The right side is essentially normal, but there is marked dilatation and tortuosity on the left side and the bladder is compressed.

This patient's right ureter was probably in a crevice between two myomatous nodules, but on the left side she had a large intraligamentous nodule which had compressed the ureter and therefore caused this dilatation. Following delivery it takes about six weeks for the dilatation to subside, for complete involution to take place. I think



Fig 10

that is where the hormonal effect comes in, because this (Fig 8) shows postoperative pyelograms on this patient within ten days after operation and there is complete involution.

These next two cases, I think, illustrate the effect of pelvic inflammatory disease on ureters and the production of ureteral stricture. Figure 9 shows a patient with a fibroid, soft tissue shadow coming up about to the pelvic brim, very marked dilatation on both sides, and very poor function on the left side. You can hardly see any visualization on the left side. At operation this patient was found to have fibroids plus a large tubo-ovarian



Fig 11

abscess on the left side. Postoperatively she was studied by retrograde pyelograms.

This (Fig 10) is the right side, where there



Fig 12

had been little if any inflammation and there is almost complete involution. This is a pretty normal looking tract. Figure 11 shows the left side where the tubo-ovarian abscess had been. This is a typical picture of an advanced chronic pyelonephritis, with greatly dilated blunted calyces, very thin cortex and a marked stricture in the lower left ureter.

The next three slides are very similar to these, but have a different basis.

This (Fig 12) was a young girl only 19 years of age who had a large pelvic abscess which I think was probably a pseudopelvic abscess—that



Fig 13

is, instead of being a true abscess just walled off by intestines, it was probably a left-sided tubo-ovarian abscess which had prolapsed into the cul-de-sac. I say this because the follow-up studies on her again show pretty normal involution on the right side (Fig 13) and a stricture of the lower left ureter with continued dilatation of the pelvis, calyces and ureter above the point of constricture (Fig 14).

Figures 15 and 16 show retrograde pyelograms on a patient who had a complete prolapse of the uterus. Here the dilatation comes much further



Fig 14

down. You can see it better on the left side. The lower dilatation occurs because the constriction from prolapse is due to the angulation and turning



Fig 15

back of the lower ureters under the prolapsed uterine vessels.

We made postoperative studies of this patient, but I did not reproduce them because they showed no change. We feel that the reason there was no change was because this patient did have a chronic urinary tract infection, and in chronic infection the tissues lose their elasticity and their ability to undergo involution. When the dilatation of pregnancy was more frequent and more difficult to control than it is now (and sometimes these individuals during pregnancy were infected for a long time), we used to get persistence of the pregnancy



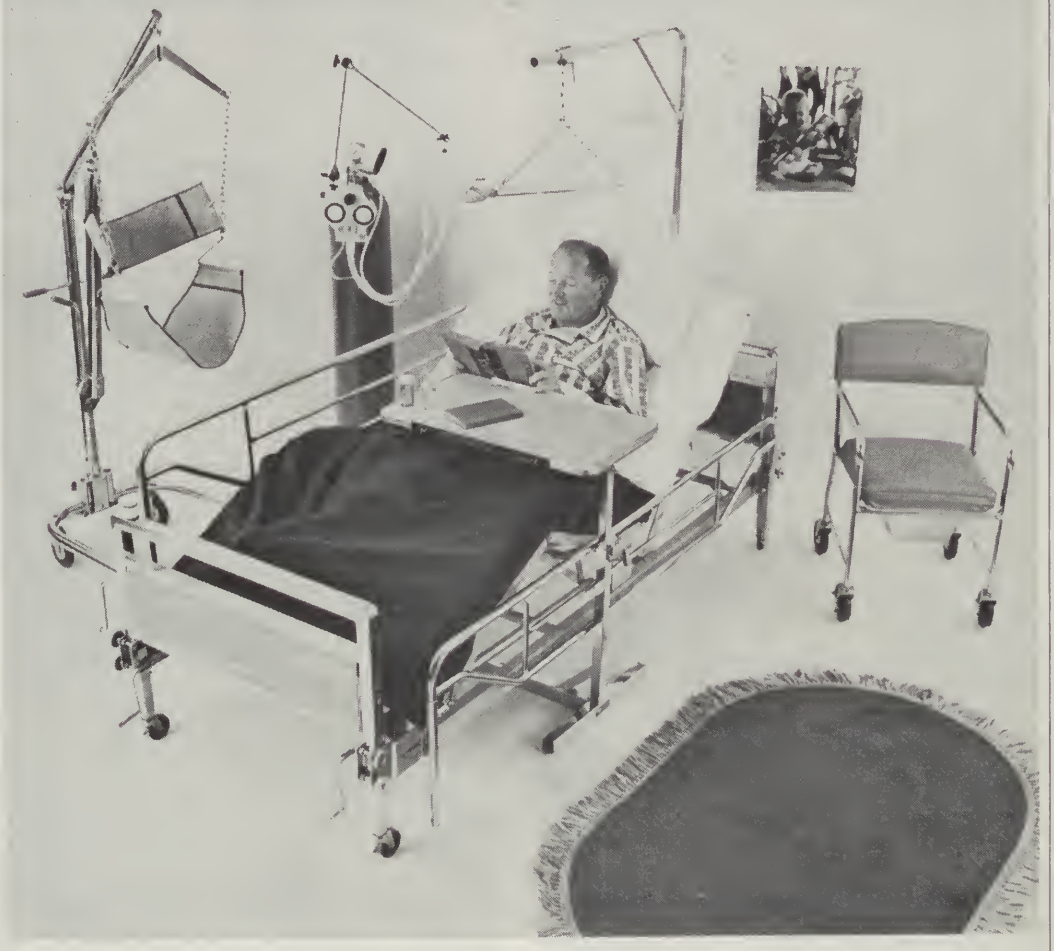
Fig 16

dilatation permanently. And we still see that every now and then.

So, to summarize, I may say that I agree thoroughly with Dr. Fetter that obstructive lesions, or stases, are most important factors in the causation and the maintenance of urinary tract infection; that I do not think the presence of temporary infection in the bladder following catheters is of great importance; and that the great gadgetry that has developed as a result of this has been entirely overemphasized.

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CARCINOMA OF THE VOCAL CORD

JERRIE CHERRY, MD
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The Johns Hopkins University School of Medicine

Cancer of the larynx occurs most often on the true vocal cords in males with a history of smoking. This cancer indicates its presence early by hoarseness, and the diagnosis is established by laryngoscopy and biopsy. Ninety per cent of these early true vocal cord lesions can be cured by either radiotherapy or surgery.

Any patient with voice change persisting longer than three weeks should have a direct laryngoscopy to establish the diagnosis.

The incidence of cancer of the larynx in the general population is about 3 per 100,000, with 70% of these cancers beginning on the true vocal cords. If diagnosed early, they offer an excellent chance of cure, 90%

Laryngeal cancer occurs nine times more frequently in men than in women and is seen most often in smokers of long standing.

As laryngeal cancer occurs so often on the true vocal cords, it makes its presence known by voice changes relatively early in the disease. At first this voice change may be an intermittent huskiness, as the true vocal cords overcome the mechanical obstruction to their complete closure for short periods of time. As the tumor mass enlarges or as peritumor inflammatory reaction continues, the voice becomes constantly hoarse or husky. Patients rarely seek medical aid prior to persistent voice change, in part explaining the usual 10-month delay from onset of symptoms to diagnosis.

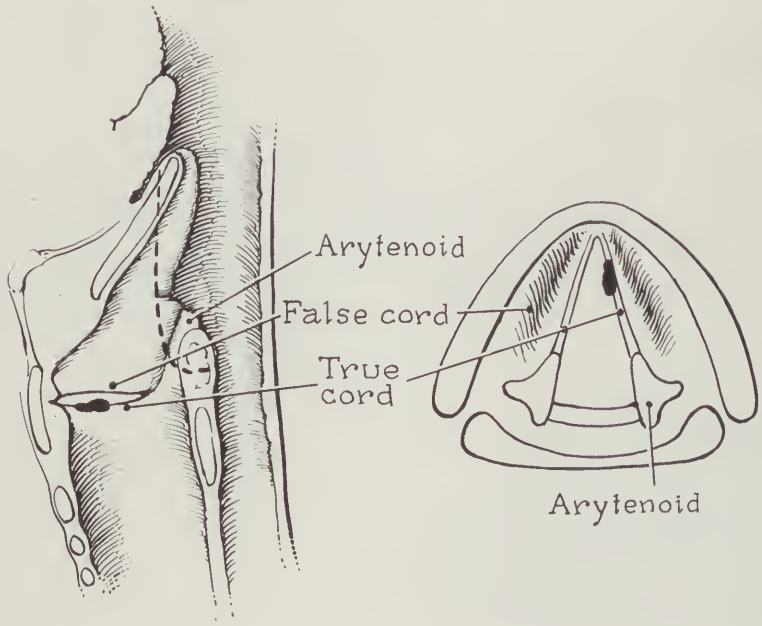
The true vocal cord is a tendonous band extending medially from the vocalis muscle and it is covered by a thin mucosa containing a meager lymphatic system. Thus, early or rapid spread of cancer within the larynx or beyond the larynx is seldom a feature of true vocal cord carcinoma.

Pain is seldom associated with this lesion, although the patient may cough, complain of vocal fatigue, and make frequent efforts to clear his throat. Swallowing is invariably normal, as a true vocal cord lesion is within the larynx. True cord cancers may occur anywhere on the vocal cord, but the free edge of the anterior third is the most common location.

The diagnosis of laryngeal cancer is made upon inspection of the larynx and confirmed by biopsy. As the larynx is hidden from view, it is impossible to make an accurate appraisal of laryngeal disorders without laryngoscopy. The importance of direct laryngoscopy to adequately assess the extent of the disease cannot be overemphasized.

Small true vocal cord lesions (Fig) have a gray to pink granular texture, as opposed to the smooth white glistening normal mucosa of the vocal cords. Vocal cord mobility is normal with true cord cancers, becoming immobile only with advanced lesions. Early lesions of the true cord seldom present with cervical node metastases.

Anatomy of the endolarynx. A small lesion is present on the anterior one-third of the right cord.



Solitary vocal cord cancers are treated with about equal success by surgical excision of the involved vocal cord or by radiotherapy. Each has certain advantages which would dictate its choice in each case. The main advantage of irradiation over surgical excision is a more normal voice after therapy. The inherent disadvantage of irradiation is the effect of 5,000 rads to the larynx and adjacent tissues. Partial excision of a vocal cord results in varying degrees of hoarseness, but surgical excision has three advantages over irradiation: 1) large doses of irradiation are avoided; 2) the extent of disease is accurately determined at operation; 3) the proof of adequate excision can be demonstrated by histologic section. Irradiation seems indicated in older patients and in patients whose voice is important for occupational or social reasons. Surgical excision moy be preferable in younger patients whose life expectancy is such that large doses of carcinogenic irradiation are contraindicated.

Patients treated by either means should be seen at regular intervals for the rest of their lives. Second primary lesions within the larynx are common, and bronchogenic carcinoma has been shown to develop in a high percentage of patients with laryngeal cancer.

The Johns Hopkins University
School of Medicine
Baltimore, Md. 21205

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References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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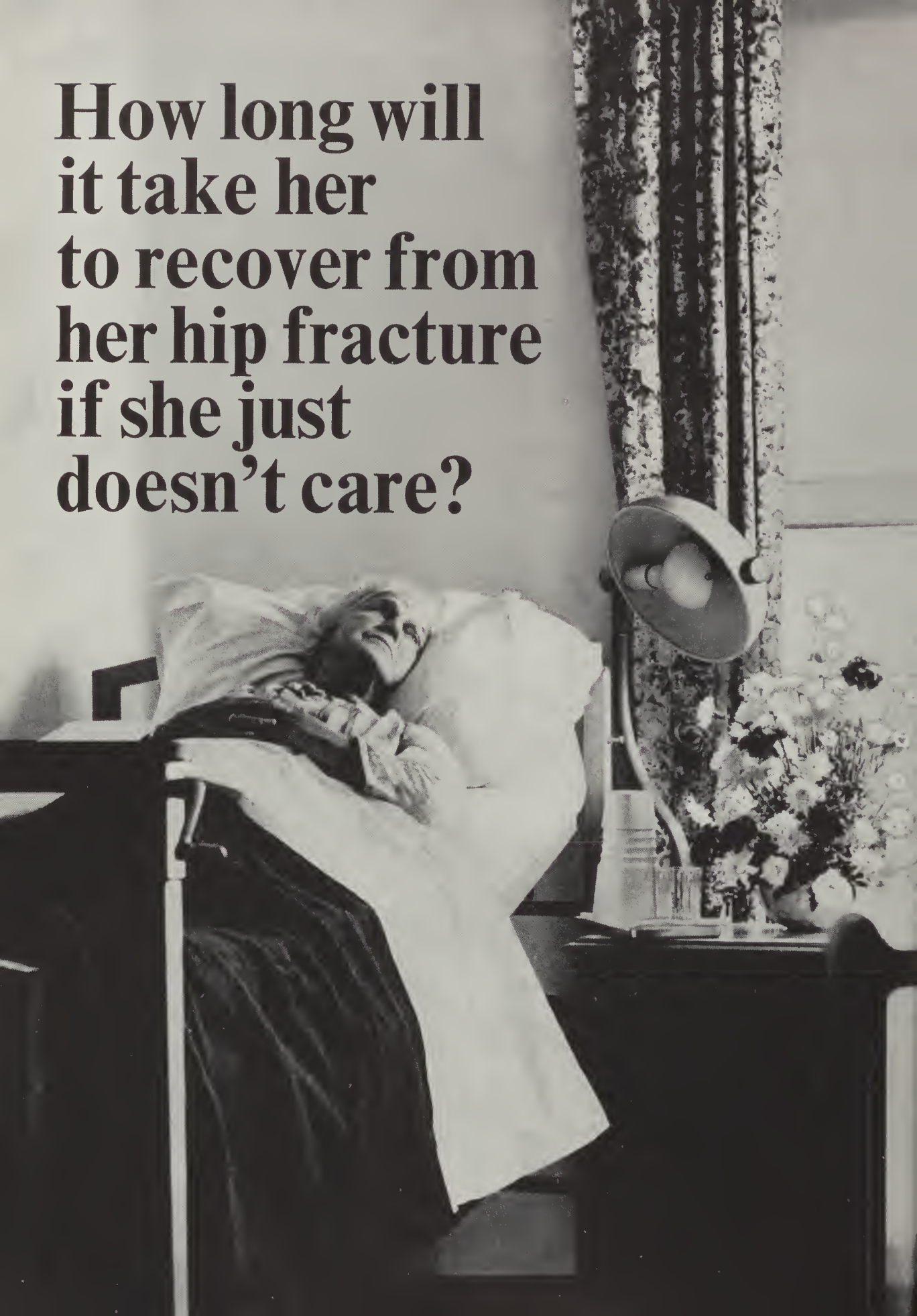
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THE DEMOGRAPHY OF MENTAL ILLNESS IN MARYLAND

KURT GORWITZ
Statistics Director
State of Maryland Department of Mental Hygiene

Enumeration of the mentally ill in the United States was first attempted in 1840. U.S. marshals accumulated the data, each according to his own undefined methods, and results were wholly unreliable. At that time, half a dozen state-operated mental hospitals and a number of private mental institutions were in existence, but most of the mentally ill were still housed in jails, almshouses and other public facilities. In the intervening 125 years, both enumeration procedures and care facilities have been vastly improved, primarily at the State level. Maryland, world-wide leader in the statistical area, has reliable data from its Psychiatric Case Register on which to base answers to many questions now asked about the extent and treatment of mental illness. Questions and answers are presented here.

Efforts to count and analyze the segment of our population considered to be mentally ill originated in this country about 150 years ago. On a federal level, the first attempt at enumeration was made in 1840. The U.S. Census Bureau had not yet been established and the local marshals had the responsibility for conducting the census. One of the questions sought to determine the number of what were called "insane or idiots" in their area. No effort was made to divide these groups and no definitions were provided. Each marshal was, in effect, free to include or exclude as he saw fit.

The official records indicate that a total of 17,434 such people were enumerated. Of these, 528 were Maryland residents. Both in this state and in the rest of the country, this was equal to a rate of slightly more than ten per 10,000 total population; however, there were wide variations reported within states and between states. It is therefore not surprising that in 1843 the American Statistical Association deemed it necessary to send a formal letter to the U.S. House of Representatives protesting the accuracy of the 1840 census. The letter singled out the data on "insane and idiots" as being particularly unreliable.

This census reported a higher rate of insanity among free Negroes than among slaves. Despite the gross inaccuracy of these statistics, the data were subsequently stated, in the U.S. Congress, to be one justification for the retention of slavery.

In 1850, the enumeration was repeated, but separate counts were obtained for those considered to be "insane" and those considered to be "idiots." The official report indicated that roughly six out of every 10,000 residents were insane and an equivalent number were idiots. Maryland's

Based on a talk presented at the Phipps Psychiatric Unit of the Johns Hopkins Hospital, November 4, 1964, and on a paper given at the annual meeting of the American Association for the Advancement of Science, December 27, 1965.

reported rate for idiots was similar to the national figure. The rate of insane, however, was reported to be substantially higher, a fact which caused speculation as to whether this reflected greater mental illness here or merely differences in reporting.

Similar data were collected in each census from 1860 to 1890. The enumeration was discontinued in 1900 because it was felt that accurate information was not obtainable. No nationwide attempts have been made since 1890 to enumerate the mentally ill.

In 1880 the data obtained by the census enumerators were supplemented by written inquiry of physicians and of facilities for the mentally ill and the mentally retarded. Data on 17% of the enumerated insane were obtained solely through responses from physicians. As a result of this endeavor, rates in this census were considerably higher than those reported in earlier and subsequent enumerations. In Maryland, for example, the rates of mental illness and mental retardation were stated to be 198.6 and 141.1 (per 100,000 population), respectively.

A comparison with current estimates, however, shows that these reported rates were still very low and indicates substantial under-enumeration, particularly among the borderline retardates and the non-psychotic types of mental disturbances. According to latest available data, more than one percent of Maryland's total population are under care of a psychiatric inpatient or outpatient facility at some time during a one-year period. Many others are believed to receive supportive services for mental disturbances through private practice, and nonpsychiatric agencies and programs. Currently accepted estimates are that one-half of one percent of the population are severely retarded, with an additional two and one-half percent more moderately retarded. In Maryland, 0.7 percent of the population attend public school classes for the educable and trainable retarded, with an additional 0.3 percent in hospital and community facilities.

In 1773 the first public mental hospital was established in Williamsburg, Virginia. It is interesting to note that a general hospital in Philadelphia accepted mental patients from its inception in 1752. The first private mental hospital (The Friends Retreat in Pennsylvania) opened shortly after this. Both were founded largely as a result of the Quakers' efforts. By the time of the 1840 census half a dozen state-operated facilities and a number of private hospitals were in existence. One of these was the predecessor of the Seton Institute in Baltimore. Another was Maryland's first state-operated hospital for the insane, the Maryland Hospital, which began accepting mental patients in 1797 as part of a general hospital program. It was located in Baltimore in the Johns Hopkins Hospital area and, intermittently, privately and publicly operated. Its program was limited to the care of the mentally ill by legislative action in 1839. It moved to what is now the Catonsville area in the 1850s when it became known as the Spring Grove State Hospital. Some of these facilities maintained patient statistics from their inception and Goldhamer and Marshall analyzed some of this information in the book, "Psychosis and Civilization."

Most mentally ill, however, continued to be kept in jails, alms houses and other public institutions, often under the most inhuman conditions imaginable. The Sylvan Retreat, a county-operated mental hospital in Cumberland, still has in its basement the dungeons which at one time were used to hold "unruly" patients. A visit with her Sunday School pupils to the House of Correction in East Cambridge, Massachusetts, in 1841 changed the life of a remarkable and largely forgotten woman named Dorothea Lynde Dix. She devoted her remaining years to a crusade on behalf of the mentally ill which carried her to every part of this country and to much of Europe. In Maryland, as in many other states, she addressed a joint session of the legislature. In 1854 she induced the U.S. Congress to adopt a bill which provided that proceeds from the sale of 12 million acres of public lands be used for the care of the mentally ill. If this bill had not been vetoed by President Pierce, mental health programs in Maryland and other states would undoubtedly have been drastically changed.

In general, statewide mental health programs were not formally organized until much later. In Maryland, for example, the State Lunacy Commission which preceded the Mental Hygiene Department was not established until 1886. Maryland's second hospital for the mentally ill, the Springfield State Hospital at Sykesville, was founded shortly after this date. In New York State, care of the mentally ill remained the legal

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responsibility of the county poor houses until about the same time. In many states, the assumption of state responsibility for the treatment of the mentally ill was preceded by acrimonious legislative debate instigated by representatives of those with a vested interest in maintaining the bulk of the mentally ill in county homes.

Until the establishment of a state mental health authority, statistics, if available, were generally limited to specific individual facilities. In most states where centralized mental health statistics programs were ultimately established, these data served administrative purposes and were concerned primarily with measuring the flow of patients into and out of publicly operated psychiatric hospitals and in describing some of the demographic characteristics of this population. In more recent years, with the development and rapid growth of psychiatric clinics and other outpatient programs, statistical services increasingly have been concerned also with comparable data for these facilities. In Maryland and most other states, statewide data on treated mental illness are therefore of recent origin.

Statistical data of most states continue to be limited to state-operated and state-supported hospitals and clinics. Since they generally exclude federal (VA) and privately operated mental health facilities, they usually cannot provide any indication as to the total amount of psychiatric services provided. In addition, because of the lack of a ready mechanism for eliminating the duplication of multiple treatment services, these data cannot be used to study rates of treated mental illnesses, variations in treatment rates and modalities for different population segments, and the relationship of these rates to socio-economic variables and other public health indices. Community investigations, such as the recent Midtown Manhattan study, while being more comprehensive, similarly suffer from a lack of longitudinal data regarding the course of the illness, and of the sequence and extent of services provided for the condition.

The limitations of these types of statistical programs should be particularly clear if we take cognizance of the rapid growth in recent years in the number and variety of psychiatric facilities and in the coordination of their services. This expansion, together with the current emphasis on short-term intensive treatment, during the acute

stages of illness, followed by continuing supportive services, has produced an increasing number of individuals who receive multiple treatment services during a given time period—often in different facilities.

Maryland has attempted to overcome some of the deficiencies indicated here through the development of a psychiatric case register based on unified reporting from nearly all public and private inpatient and outpatient psychiatric facilities. The concept of case registers is not new. They have been established and maintained in the United States and in other countries for many years in such other public health fields as tuberculosis, venereal diseases, rheumatic fever and cancer. Usually, they consist of an up-to-date alphabetic listing of all individuals known to have had the illness at some time, together with demographic information and a sequential record of the services received for this condition. While these registers can be an important research tool, it should be clear that they cannot be used for the computation of true incidence or prevalence rates since an undetermined number of cases would not be known to any of the register sources.

The Maryland Psychiatric Case Register, a research project administered by the Department of Mental Hygiene in cooperation with the National Institute of Mental Health, has been in existence since July 1, 1961. It is based on reports of all admissions and terminations submitted by more than 130 psychiatric facilities which are estimated to treat in excess of 98% of all such patients. It encompasses the entire state, with its population of three and one-half million people, and is the largest operational register of its type in the world at the present time. In the United States, the next largest register is in Monroe County, New York, and serves a population of approximately 600,000. The confidentiality of all register information is protected in Maryland by a state statute adopted in 1963 which legally safeguards data collected for health research purposes.

WHAT IS THE CURRENT EXTENT OF MENTAL ILLNESS IN MARYLAND? We do not have the answers to this question since this would require some type of community investigation. Because of the Maryland Psychiatric Case Register, however, we do have some information regarding the extent of treated mental illness. The following are the answers to some basic ques-

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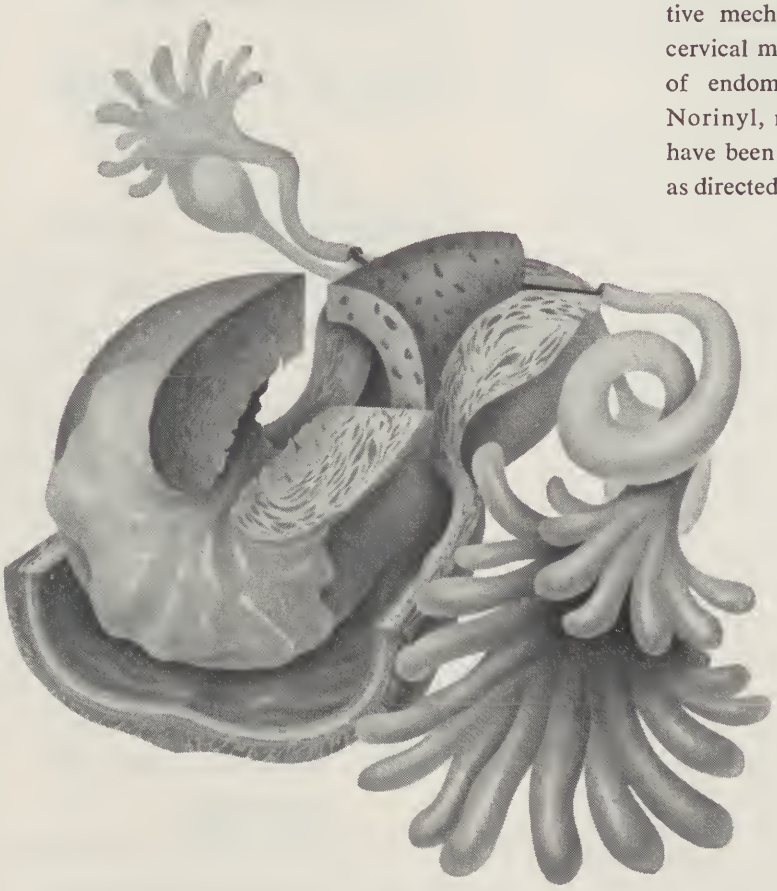
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Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

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tions. It should be kept in mind that all figures mentioned here are based on unduplicated counts of individuals:

1. How many people are treated in psychiatric facilities? Latest available data indicate that more than 35,000, or one percent, of Maryland's residents receive treatment in a psychiatric facility at some time during a one-year period. This rate has increased in recent years, both because of the expanding numbers under care in public and private mental hospitals and because of the opening of a number of clinics and other outpatient facilities. The number treated in general hospitals, while proportionally still quite small, has also increased. In the last five years, nearly 80,000 Maryland residents (or nearly 2½% of the state's population) have been reported to the register as under treatment.

2. How does this vary by age and sex? Age-specific rates have been consistently higher for males than for females. This disparity has been accounted for primarily by a five to one male-female ratio among patients diagnosed as alcoholics. Excluding this group, more females than males were under psychiatric care in most age and diagnostic cohorts. The maximum proportion of the population under care (nearly two percent) has been in the age group 65 and over. Much of this has been accounted for by long term, custodial patients who occupy one out of six beds in the state mental hospitals. The number of older patients in outpatient facilities has remained minimal. Among admissions, however, the highest rate has been in the age group 35 to 44 (0.8 percent per year).

3. Do rates differ in Baltimore City and in the rest of the state? Baltimore City rates for specific age and sex groups are, in general, substantially higher than comparable rates in the Maryland counties. Total prevalence rates are approximately twice as high in Baltimore City, a reflection of socio-economic factors, selective in-and-out migration and the greater availability of psychiatric services. It should be noted, however, that major variations are reported within Baltimor City; that is, admission and under-treatment rates for many types of mental illnesses are related to income and other economic variables and generally follow a pattern similar to other public health indices.

4. How do white and nonwhite rates differ? A comparison of white and nonwhite rates should be approached with caution since it is known that they are distorted by the fact that the socio-economic composition of the two groups differs significantly and that there may be selective use of other available resources such as private psychiatrists.

Nonwhite admission rates to all psychiatric facilities are substantially higher than comparable white rates. This difference is particularly pronounced in the state-operated hospitals where nonwhite rates are nearly twice as high as white rates. They are also somewhat larger in outpatient facilities. However, there are almost no nonwhite admissions to private hospitals, although these accounted for 15% of all white admissions.

Similar variations have been reported from other areas where comparable data are available. They provide one indication of the cost to the total community resulting from the social, cultural and economic deprivation and disorganization of Negroes in the inner core slums of America's cities.

5. How many alcoholics are treated in psychiatric facilities? The number of patients with a primary diagnosis of alcoholism is expected to exceed 6,000 during the current fiscal year. Alcoholism in many cases is one of the manifestations of psychiatric disorders. We can therefore anticipate, based on data from earlier years, that at least 2,000 patients with other diagnoses will also have major drinking problems. While some of the large increase observed in recent years in the above is due to the development and expansion of outpatient programs for alcoholics, most of it is due to the rise in these admissions to the state-operated hospitals. Latest data indicate that two-thirds of all admissions with a diagnosis of alcoholism are to one of the state mental hospitals, and that these now account for more than 40% of all patients entering these facilities.

Register data indicate that rates are highest between 45 and 54 years and that proportionally twice as many Negroes as Whites are under treatment for alcoholism during a given year (white male, 255 per 100,000 estimated population; nonwhite male, 429; white female, 75, nonwhite female, 137). This ratio is accounted

for by a large disparity up to age 45, after which point white and nonwhite rates are nearly equal. Whether or not this is related to sociocultural variations, legal factors, or to the availability of alternative resources, is not known. Similarly, undertreatment rates for specific age, sex and race groups in Baltimore City are substantially and consistently higher than in the Maryland counties.

While the total number of alcoholics in Maryland is not known, it is estimated at nearly 100,000. This would indicate that only a small proportion are receiving treatment in psychiatric facilities. Even these often receive only minimal services. In the three major state hospitals, one-tenth of alcoholics are released within one week, half within one month and almost all within one year. Available data indicate that 18 months after onset of hospitalization, 79% of alcoholics are not under psychiatric care, 5% are dead, and the remaining 16% on hospital or clinic rolls.

6. How many schizophrenics are treated in psychiatric facilities? The number of patients with a diagnosis of schizophrenia has remained almost constant since 1961, at approximately 6,400 (0.2% of Maryland's population). In the last five years, 17,000 residents have been reported to the Register as schizophrenics during one or more treatment episodes. Rates have been slightly higher for females than for males and much higher for nonwhites than for whites. The highest rates, however, are reported for separated white males between 35 and 44 years of age (more than two percent). Paranoiacs, accounting for one-third of all schizophrenic admissions, are the largest subgroup.

Many individuals receive more than one diagnosis in the course of their illness. Among admissions diagnosed as schizophrenic during the three-year period from July 1, 1961, to June, 1964, 9% were diagnosed as alcoholic during a previous or subsequent treatment episode, 6% as manic depressive or suffering from some other type of psychotic disorder, and 30% of the group as having other mental disorders.

7. How long do patients remain hospitalized in state-operated facilities and what is the probability of rehospitalization? Of the patients 25 to 54 years of age admitted to Crownsville, Springfield and Spring Grove, more than half were released within three months and more than 80% within a year. Less than one out of every twenty remained hospitalized at the end of two years. Of those released within one year, 42% were rehospitalized within the next 18 months. Psychotic patients had the lowest release rates and the highest readmission rates. Alcoholics had the highest release rates. The percentage distribution of all patients 18 months after original admission was as follows: hospitalized continuously, 5%; released and rehospitalized, 9%; on hospital leave, 9%; on clinic rolls, 10%; dead, 3%; alive and not under psychiatric care, 64%.

8. Does the life expectancy of the mentally ill differ from that of the general population? Preliminary data indicate that the life expectancy of the mentally ill is lower than the comparable general population figure. A study among patients admitted to Maryland's three major psychiatric hospitals indicated high mortality rates, both during hospitalization and after release. Among alcoholics, death rates were up to nine times as high as rates in the general population of the same age and sex. Mortality rates were also substantially higher among the psychotic and psychoneurotic. While deaths from suicide were proportionately more frequent among the mentally ill, particularly the psychoneurotic, they accounted for only a portion of the disparity. Lower than average socio-economic status and greater concomitant physical illnesses are believed to be other factors related to these differences.

9. How do Maryland rates compare with those of other states? Comparisons with other states are not possible since similar statistics are not available elsewhere on a statewide basis. Data for public mental hospitals alone indicate that, proportionately, Maryland has fewer mental hospital beds but a greater turnover in the patient population. The greater admission and release rates in Maryland are accounted for, in part, by alcoholics receiving short-term treatment. A number of other states do not accept such patients in their state mental hospitals.

10. Do these data provide any indication of possible future trends? Register data indicate that while the number of Maryland residents treated in psychiatric facilities has increased, they still comprise only a small proportion of the state's population. Recent community investi-

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gations, such as the Midtown Manhattan study, have reported that approximately one in every five persons shows major symptoms of mental disturbance. The application of these data to Maryland indicates that many residents with mental illness either are untreated or receive supportive services through non-psychiatric agencies and resources, and that the currently planned expansion of outpatient facilities in the state, and the development of new community-centered programs, may not reduce the flow of patients to the state mental hospitals. Rather, they may result in an expanding total patient load, the provision of services to many population segments previously untreated, and the improvement of patient care through the development and application of new treatment concepts and the coordination of services.

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vignettes of angina pectoris—
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angina and the surgeon

John Hunter—
British surgeon (1728-1793)

angina of anger

"My life is in the hands of any rascal who chooses to annoy and tease me."[1] So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."[2]

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."[3] So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that Hunter would read it, and hav "his fears excited by its truly formidable nature."[4]

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed death and performed an autop gave this account of the later s of the condition:

"...the pain became excruciat at the apex of the heart; the th was so sore as not to allow of a attempt to swallow anything a the left arm could not bear to be touched....

"The affections above describe were, in the beginning, readily brought on by exercise... but t at last seized him when lying in bed, and in his sleep...."[5]



18th century ancestor of the modern coronary candidat Surgeon, anatomist, patholog physiologist, geologist, and tea Hunter had a passion for resea which led him to disregard his practice, his health and even t

When the Irish giant O'Brien
ied that Hunter desired his
ton for a museum, he willed
his body be sunk at sea in a
coffin. But Hunter was not to
nied. According to Major, he
ribed the watchers and finally
ined the body at a cost of 500
uds although he had to borrow
noney to pay the men."[3]
'67, he experimentally inocu-
himself with gonorrhea and
ilis, treated himself with
ury for three years, and was
rently cured.[5] Hunter had
gs of inadequacy about his
ation and speaking ability,
his did not prevent him from
g hard driving and abrupt
his colleagues. His competi-
ess with his physician older
er was also well known, and
d in complete estrangement
een the two men.[2,3] Today, the
nality traits seen in John
ter are recognized to be impor-
redisposing factors in the devel-
nt of coronary artery disease—
manifested as angina pectoris.
rding to Friedman and Rosen-
[6] in a group of men whose be-
r was characterized by intense
tion and competitive drive,
ter than average incidence
gina pectoris was among those
rmal conditions noted.

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Actions: The exact cause of angina pectoris (that is, the pain associated with coronary artery disease) remains obscure, despite the numerous and often conflicting hypotheses concerning its pathophysiology. Therapy at the present time, therefore, remains essentially empiric. Customarily, clinical improvement has been measured by: reduction in (1) number, intensity and duration of angina pectoris attacks and (2) necessity for glyceryl trinitrate intake for prevention or relief of anginal attacks.

Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake.

In the evaluation of Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. in angina pectoris, clinical improvement has been customarily measured subjectively by reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to antianginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. have been accepted as safe for prolonged administration and widely regarded as useful.

Animal pharmacology: In a series of carefully designed studies in pigs, Peritrate (pentaerythritol tetranitrate) was administered for 48 hours before an artificially induced occlusion of a major artery and for seven days thereafter. The pigs were sacrificed at various intervals for periods up to six weeks. The result showed a significantly larger number of survivors in the drug-treated group. Damage to myocardial tissue in the drug-treated survivors was less extensive than in the untreated group. Pigs rather than dogs were used because their coronary artery distribution more closely resembles that of human beings. Studies in dogs subject to oligemic shock through progressive bleeding have demonstrated that Peritrate (pentaerythritol tetranitrate) is vasoactive at the postarteriolar level, producing increased blood flow and better tissue perfusion. These animal experiments cannot be translated to human behavior

Indications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is indicated for the relief of angina pectoris (pain associated with coronary artery disease). It is not intended to abort the acute anginal episode but is widely regarded as useful in the prophylactic treatment of angina pectoris.

Contraindications: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. is contraindicated in patients who have a history of sensitivity to the drug.

Warning: Data supporting the use of Peritrate (pentaerythritol tetranitrate) during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

Precautions: Should be used with caution in patients who have glaucoma.

Adverse reactions: Side effects reported to date have been predominantly related to headache (which may require discontinuation of medication) and gastrointestinal distress which are usually transient with continuation of medication.

Dosage: Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg., 1 tablet immediately on arising and 1 tablet 12 hours later (on an empty stomach).

Additional dosage forms
Peritrate (pentaerythritol tetranitrate)—10 mg. and 20 mg. tablets with or without phenobarbital.

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MEDICAL AND LEGAL ASPECTS OF HUMAN STERILIZATION

JOHN WHITRIDGE, JR., MD
Associate Professor of Gynecology and Obstetrics, The Johns Hopkins University School of Medicine

RANDALL C. COLEMAN
of the Baltimore Bar

Proposed legislation for compulsory sterilization of humans in certain circumstances would not accomplish the objectives of its proponents, and is both medically and legally unnecessary. Indeed, it may even be restrictive to a point of being more harmful than beneficial. The expense of such a program would be prohibitive, although its positive effects would be only minimal.

From time to time, legislation has been introduced in the Maryland General Assembly relating to surgical sterilization of humans. Currently the Maryland law is silent on this subject, there being no statutes whatever relating to it. In addition, there has recently been considerable interest in and discussion of national legislation on both sterilization and abortion. Volumes have been written on this topic, many aspects of which are highly controversial. Religious and moral issues are particularly involved. We will confine ourselves largely to the medical and legal aspects of human sterilization, however, so that the profession and the public alike may better understand what is at stake.

The expressed objectives of those Maryland legislators who have recently sponsored this type of legislation are five in number. First, sterilization is a desirable and effective method of population control. Second, sterilization would be effective in controlling the number of children born to unmarried women. Third, if sterilization were given legal status, physicians generally would be less reluctant to carry out the procedure. Fourth, legislation would enable the courts to order compulsory sterilization of individuals with certain types of hereditary forms of mental illness, mental deficiency, etc. Fifth and last, an adequate law on sterilization would tend to discourage one marital partner from the sterilization procedure without the consent and knowledge of the other partner.

The first two of these objectives are largely medical in nature. The fourth is a combination of medical and legal considerations, and the remaining two principally involve legal aspects.

Prior to discussion of details, it should be noted that this subject was reviewed in July, 1963, by an ad hoc committee of the Medical and Chirurgical Faculty of the State of Maryland, under the chairmanship of Richard W. TeLinde, MD, professor emeritus of Gynecology, The Johns Hopkins University School of Medicine. The committee decided to "go on record as seeing no need for any law regarding the sterilization of incompetent persons," and reported the following conclusions: "In summary, it was the general feeling of the committee members that no legislation pertaining to sterilization of humans is needed in Maryland at the present time. Adequate

procedures are now available to accomplish sterilization, and any legislative act might tend to severely limit the procedure."

Medical Aspects

Termination of the ability of humans to reproduce can be accomplished in a variety of ways. The most common procedure in females is tubal ligation, whereby the continuity of the fallopian tube is interrupted, and the union of spermatozoa and ovum thus prevented. Hysterectomy and several other surgical procedures on females also effectively prevent further childbearing. In the male, the usual procedure is vasectomy, whereby the male is rendered sterile but not impotent. Both tubal ligation and vasectomy are usually considered irreversible; that is, the result must be generally regarded as a permanent one, although it is technically possible to restore the continuity of the fallopian tubes or vas deferens.

From the medical viewpoint, it is important to bear in mind that tubal ligation is not a completely innocuous procedure. In 1955, Eastman and Prystowski, reporting from The Johns Hopkins Hospital,[1] presented data on 1,830 consecutive tubal sterilization procedures. Three women died as a direct result of the operative procedure, with a resulting mortality rate of 1 per 600 procedures. This is not surprising, since the performance of tubal ligation requires entering the abdominal cavity and the administration of anesthesia. Admittedly the risk is slight, but it is nonetheless present.

In the proposed laws introduced in recent years, the procedures specifically to be made legal were limited to salpingectomy and vasectomy. Salpingectomy, by definition, is "complete removal of the fallopian tube" and such legislation would therefore raise doubts as to the legality of the most common and the safer procedure of tubal ligation. The legislation, as introduced and as existing in several other states (eg, Virginia), also requires a thirty-day waiting period between the time written permission is given for sterilization and its performance. Such a provision automatically eliminates any opportunity to carry out the procedure under emergency conditions such as an emergency cesarean section, appendectomy, or any other operative procedure requiring an abdominal incision.

1. **Population control.**—It is true that surgical sterilization, if carried out on a wholesale basis, would be a highly effective method of controlling population growth. The major disadvantages to using this approach to lowering the birth rate are two, namely, risk and cost. The risk involved in carrying out tubal ligation on females has already been mentioned. Vasectomy in the male is, however, usually an office procedure and virtually devoid of risk. The question, medically, as it relates to vasectomy is largely one of how acceptable this procedure would be to large numbers of American males.

In regard to sterilization of females, the cost would be prohibitive if sufficient numbers were involved to have any significant impact on the birth rate. Data prepared by the Division of Statistical Research and Records of the State of Maryland Department of Health indicate the following. If a policy were adopted to offer sterilization to every woman in Maryland under the age of thirty who had had three or more children, and if it is assumed that all these women would agree to sterilization, during the first year of such a program 50,000 procedures would be necessary. This would result in reducing the birth rate from approximately 23 to 20 per 1,000 population. If an average minimal cost of $200 is further assumed (this would include hospital bill and physician's fee), the first year's program would cost a total of $10 million. To continue, in subsequent years, sterilizing all women under thirty who had had three or more children, would require about 10,000 procedures annually at a cost of $2 million a year.

In view of the rapid advances that have been made and further developments that can be expected in the field of contraceptive methods, the cost of sterilization versus more wide-spread use of conventional contraceptive methods must be compared. For example, if instead of being sterilized, the 50,000 women noted above could be given oral contraceptives, the total cost in a year would be approximately $600,000 instead of $10 million. Insertion of an intrauterine device would be appreciably less expensive. And there is an additional factor to be re-emphasized, namely, that the results of sterilization are usually permanent. For a variety of reasons, couples or individuals may and do change their minds about the desirability of having more children. One or more living children may die, there may be a remarriage, or

other factors may prompt a woman to desire more children. The advantages of the conventional birth control methods in this respect are obvious.

2. Control of out-of-wedlock Births—In 1964, 3,764 births in Maryland counties were recorded as "illegitimate." Of these, 1,845 occurred in women having a first pregnancy and 685 in women having a second pregnancy. This means that 67.2% of all children born to unmarried mothers were the result of either a first or second pregnancy. If, therefore, the usual provision in proposed legislation dealing with compulsory sterilization after a second pregnancy were enacted, slightly less than one-third of the problem, at best, would be solved. Even if so radical a step as carrying out compulsory sterilization of all unmarried mothers after one pregnancy were enforced, this would affect only slightly more than half the problem. Since it is obviously impossible to determine *beforehand* precisely which unmarried girls and women will become pregnant, sterilization does not appear to be a logical means of attacking this growing social, health and moral problem.

This topic cannot be dismissed without reference to the matter of the personal rights of the individual. Since the vast majority of women who have had a pregnancy out of wedlock ultimately marry and raise a family under conventional circumstances, the moral and legal right to carry out compulsory sterilization on these grounds is open to serious question.

3. Compulsory sterilization of Defectives—From the medical viewpoint, the problem of principal concern here is that of determining which conditions are clearly hereditary. There is considerable disagreement among the experts as to the scientific evidence of precise hereditary factors in individual cases of many types of conditions. If the experts cannot agree, will not the courts find it difficult to decide in each individual case whether sterilization is, in fact, in the best interests of the individual and of society? It seems highly likely that the courts of law would find it necessary to establish special review committees or commissions to protect the rights of the individual and to give the courts expert advice on the merits of sterilization in each individual situation.

In the matter of sterilization of the severely mentally retarded, there is the consideration of their fitness to be adequate parents, irrespective of any hereditary factors involved. Even in the absence of a law on sterilization, sterilization of the severely retarded is being carried out by physicians with the written permission of a parent or legal guardian.

Legal Aspects

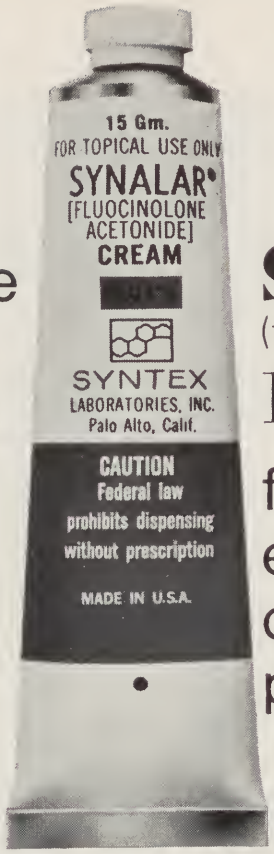
To what risks, if any, do physicians within the State of Maryland subject themselves by the performance of voluntary human sterilization procedures? There are two possible areas of liability, criminal and tort, which may be broken down roughly as follows:

1. Criminal liability
   a) Mayhem and assault
   b) Public policy
2. Civil liability
   a) Tort
   b) Contract

1. Criminal Liability—At the present time there is no express authorization for, nor restriction upon, the performance of voluntary human sterilization procedures within the State of Maryland. Normally, therefore, there should be no criminal liability since the performance of such an operation is not violative of any statutory restriction. The question of criminal liability is not quite so simple. Nevertheless, we believe the likelihood of a physician's being held criminally liable to be so remote as not to constitute any real threat to him.

There appear to be only two possible crimes which a physician performing a sterilization operation might commit: assault and mayhem. Insofar as assault is concerned, it seems highly unlikely that a court would consider sterilization a criminal assault, especially when the patient has consented. In one reported case, *Taylor v State*,[2] the defendant was charged with an assault with intent to commit an unnatural sexual act (sodomy) to which there was consent by the prosecuting witness, a 15-year old boy. In holding that the consent of the prosecuting witness was not a valid defense, the Court of Appeals relied on the public policy behind a special Maryland juvenile delinquent statute, that the act itself was considered a breach of the public peace and therefore a crime against the public generally. The indication is

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clear in the decision of the Court of Appeals that the consent of the prosecuting witness would have been a valid defense to the defendant but for these circumstances. It is submitted that there is no likelihood whatever of sterilization being put in the same category as a breach of the public peace or a crime against the public generally.

The crime of **mayhem** should likewise be considered in the same light as assault. A Maryland statute creating a crime similar to mayhem reads as follows:

> "Every person, his aiders, abettors and counsellors, who shall be convicted of the crime of cutting out or disabling the tongue, putting out an eye, slitting the nose, cutting or biting off the nose, ear or lip, or cutting or biting off or disabling any limb or member of any person, of malice aforethought, with intention in so doing to mark or disfigure such person, shall be sentenced to the penitentiary for not less than two nor more than ten years."[3]

The *American Bar Association Journal,* in discussing the relationship between sterilization and the crime of mayhem, although noting that a decision fixing criminal liability might legitimately be reached, nevertheless concluded:

> "Under the provisions of the common law, vasectomy and salpingectomy could hardly constitute mayhem. The elements of 'rendering one less able to defend himself' or to 'fight for the king' or 'less able to earn his own living' are not results of the operations as they are now performed. Unless the courts could find in the common law definitions of the crime of mayhem something to indicate that it was intended to include a prohibition of operations which produced merely an inability to procreate, then there would seem to be no basis for fixing a criminal liability."[4]

The possible violation of the Maryland statute stems from the language prohibiting the disabling of a "member," which would seem to include any organ of the body; but, since laws prohibiting mayhem were historically designed to prohibit any injury rendering the injured party a less effective member of society, human sterilization would hardly fall within the prohibition.

In the realm of public policy, when such policy relates solely to the moral propriety of human sterilization, there is considerable doubt as to whether or not a court is the proper forum for determining that policy. Although courts are routinely called upon to enforce values upon which there is a consensus in the community, the resolution of conflicting views is within the peculiar competence of the legislature.[5]

Courts do frequently, however, usurp the function of the legislature and thus it might be well to examine the present thinking of one court, at least, on the moral propriety of a subject certainly closely related to human sterilization. In the recent case of *Griswold v Connecticut,*[6] the Supreme Court of the United States was concerned with the constitutionality of a Connecticut statute making the use of contraceptives a criminal offense. In holding the statute unconstitutional, the justices were somewhat divided as to their reasons. Some held that it was an unconstitutional invasion of the right of privacy of married persons; others, that it violated the Fourteenth Amendment in failing to protect fundamental personal rights; another, that it deprived married couples of liberty without due process of law, in violation of the Fourteenth Amendment; still another, that it violated basic values in the concept of ordered liberty. Two justices dissented; they felt that the statute violated no constitutional provisions, and stressed that there is no constitutional right of privacy.

As a matter of pure law, much is to be said for the dissenting opinion, although we feel the result reached (be it judicial legislation or otherwise) was infinitely desirable. The point, however, is that nowhere, in any of the many opinions written in a controversial case, has there been any suggestion whatever that the use of contraceptives, per se, violates public policy.

In the only reported case dealing with elective sterilization, *Shaheen v Knight,*[7] the court refused to hold that there was any public policy against such an operation on the ground that there was "no virtual unanimity of opinion regarding sterilization."[8]

2. Civil Liability—When the patient has consented to sterilization, the modern view is that such consent constitutes an absolute bar in a **tort** action for injuries resulting therefrom. Although there is conflict among authorities on the point, we are persuaded to the view that it would be un-

conscionable to allow a tort recovery in the face of the patient's consent. The matter is discussed in two law review articles, each bearing the caption *Consent to Operative Procedures.*[9]

In the fairly recent Virginia case of *Miller v Bennett,*[10] the consent of the deceased to an abortion, an infection from which resulted in her death, barred recovery by her personal representative for damages for the death. Surely if the patient's consent bars recovery when the act is immoral or illegal, then certainly consent would bar recovery when the act is neither immoral nor illegal.

Of course if it can be shown by the patient that the sterilization operation (or any operation for that matter) was performed negligently and resulted in injury, then a valid case for money damages has been made out. It is therefore appropriate to indicate the degree of skill to which physicians in Maryland are held in the performance of an operation. The leading Maryland case, *Lane v Calvert,*[11] discusses the question at length. Initially, there is a presumption that the doctor has performed his medical duties with the requisite care and skill. Thus, the burden of proof is upon the patient to show not only a lack of the requisite skill or care on the part of the doctor, but that the want of skill or care was a direct cause of the injury. The amount of care, skill and diligence required is not the highest or greatest, but only such as is ordinarily exercised by others in the profession generally under similar circumstances. The mere fact that an unsuccessful result follows medical treatment is not of itself evidence of negligence.

A very likely area of liability is in the field of **contract.** Specifically, a claim against the operating physician might well ensue if the sterilization procedure is unsuccessful—in short, a suit for breach of contract.

In a suit for breach of contract the patient is generally in a fairly good position as he has obviously undergone an operation for sterilization after a thorough discussion of it with the physician, and with one specific result in mind—absolute sterilization. Certainly a patient would question the physician on the chances of success of the operation prior to undergoing it; the operating physician must therefore be certain the patient clearly understands that the success of the operation cannot be guaranteed, and that such understanding has been adequately documented. Suffice it to say that, in the reported cases, there appears to be a reluctance on the part of the courts to permit the recovery of damages; but, as previously indicated, however, the careful physician will document his understanding with the patient so that there will be no possible misunderstanding.

Compusory Sterilization

One objective of those legislators who feel that a law on sterilization is desirable in Maryland is that it would enable the courts to order compulsory sterilization of persons with certain hereditary forms of mental illness, mental deficiency, and the like.

It is quite true that Maryland has no such enabling legislation which would grant the power to a court, board or other agency, or order compulsory sterilization of either criminals or persons with mental illness or deficiencies thought to be hereditary. More than half of the states have such statutes and they have been subject to attack in many instances; attacks on substantive due process grounds have been increasingly unsuccessful, however, since the Supreme Court's decision in *Buck v Bell.*[12] That was the famous case in which Mr. Justice Holmes, in concluding that the Virginia statute was constitutional, expressed his opinion that three generations of imbeciles are enough.

Even though at face value it certainly appears desirable to sterilize individuals with the afflictions suggested above, it is our view that, since there is so much doubt as to whether the mental deficiencies aimed at are actually transmissible, legislation would not accomplish the desired purpose, but would simply lead to confusion and complicated litigation.

Legislation to Protect the Non-consenting Spouse*

The would-be sponsors of Maryland legislation on sterilization give as a final reason for it that such a law would have a tendency to discourage one marital partner from having a sterilization

*In the excellent article in 113 *University of Pennsylvania Law Review* 415, one subheading, commencing on page 437, deals at length with legal actions by a non-consenting spouse.

procedure performed without the consent and knowledge of the other partner. Thus, we believe it well to discuss the legislation, and possible reasons therefor, as it relates to this point.

Initially a physician would, of course, be interested in knowing whether a voluntary sterilization performed without the consent, or against the wishes, of the other spouse might render him liable to such non-consenting spouse.

There are situations in which the law allows the husband a recovery for the loss of services, society, and sexual intercourse when his spouse has sustained personal injuries at the hands of the defendant (a wife in most states cannot have a similar action). But even though the husband's action for such losses is separate from the wife's cause of action against the defendant for the original tort, the husband cannot recover unless the defendant's conduct toward the spouse were tortious. Since the wife's consent to the operation renders the physician's conduct non-tortious* (assuming throughout that there has been no negligence in the performance of the physician's services), the husband has no cause of action for the losses—with the possible exception of jurisdictions where the courts both (1) hold that sterilization is against public policy *and* (2) hold consent will not preclude even a civil action.

The only other basis for liability against the defendant-physician is on the theory that the defendant's conduct wrongfully interfered with a protected family relationship. These "family interference" torts are subdivided into three groups: (1) enticing a married woman from her husband's domicile; (2) criminal conversation with the spouse (either); (3) alienation of affections of the spouse (either).[14] Maryland retains these categories (*Di Blasio v Kolodner*[15]), although other states sometimes lump all three together as "alienation of affections." It is clear that sterilization has nothing to do with the first two groups and that the physician must be sued, if at all, for alienation of the affections of a spouse. The *University of Pennsylvania Law Review* article concludes that this theory of liability is rather far-fetched and notes the tremendous practical problem of proving that the physician's performing a sterilization operation had anything to do with one spouse's loss of affection for the other.

Entirely apart from this, however, is the fact that in Maryland the cause of action for alienation of affections, or at least the right to sue and recover on it, was abolished by action of the General Assembly in 1945.[16] Not only is the action prohibited, but Article 75C, Section 8 of the Code makes it a crime for a lawyer or litigant to bring such an action; in addition, the allegations in the suit papers would not be privileged, and might well constitute a libel against the physician.

Since the physician has committed no actionable wrong, directly or indirectly, against the legally protected interests of a non-consenting spouse, it is our conclusion that a physician in Maryland may perform a sterilization at the request of one spouse, without the consent, or against the wishes, of the other spouse, and will not be liable in damages to the latter.

Conclusions

In view of the preceding, our conclusions are as follows:

1) From the medical viewpoint, there is no necessity for legislation on sterilization. Any valid objective to be achieved by surgical sterilization of humans can be readily accomplished under existing conditions. There is no doubt but that sterilization procedures in Maryland are being freely carried out at the present time, although we have no exact data as to the number being performed each year.

2) There is grave danger that legislation relating to sterilization might, in fact, end up being restrictive and thus defeat many of the purposes for which it might have been intended. Provisions limiting the types of procedures that may be performed and requiring a thirty-day waiting period are but two examples of the dangers inherent in such legislation.

3) Since all sterilization procedures now being performed in Maryland are being done by duly licensed physicians and surgeons, it is our opinion that there is no more justification for enacting a law on the circumstances surrounding sterilization procedures than there is for a law specifiying

*In an action[13] by a husband against two physicians for, *inter alia*, the wrongful surgical removal of his wife's right breast—wrongful because the husband objected to its removal, the Court of Appeals of Maryland held that "the consent of the wife, not that of the husband, was necessary" (p 170); the consent of the wife having been given, the operation was justified.

under what conditions an appendix or a brain tumor may be removed.

4) At present, the risk of legal action being brought against any licensed physician in Maryland for performing sterilization is so remote as to be negligible, provided the usual safeguard of having obtained written consent is followed.

5) We seriously doubt the validity of the suggestion that a sterilization performed without the knowledge and consent of the other spouse might bring about a rift in the marital relationship; in any event, such legislation does not appear to be necessary as a protection to the physician.

6) In view of the doubt that is so frequently present as to whether certain mental deficiencies are actually transmittible, legislation enabling courts to order compulsory sterilization on these grounds would not, we feel, accomplish the desired purpose, but would simply lead to confusion and complicated litigation.

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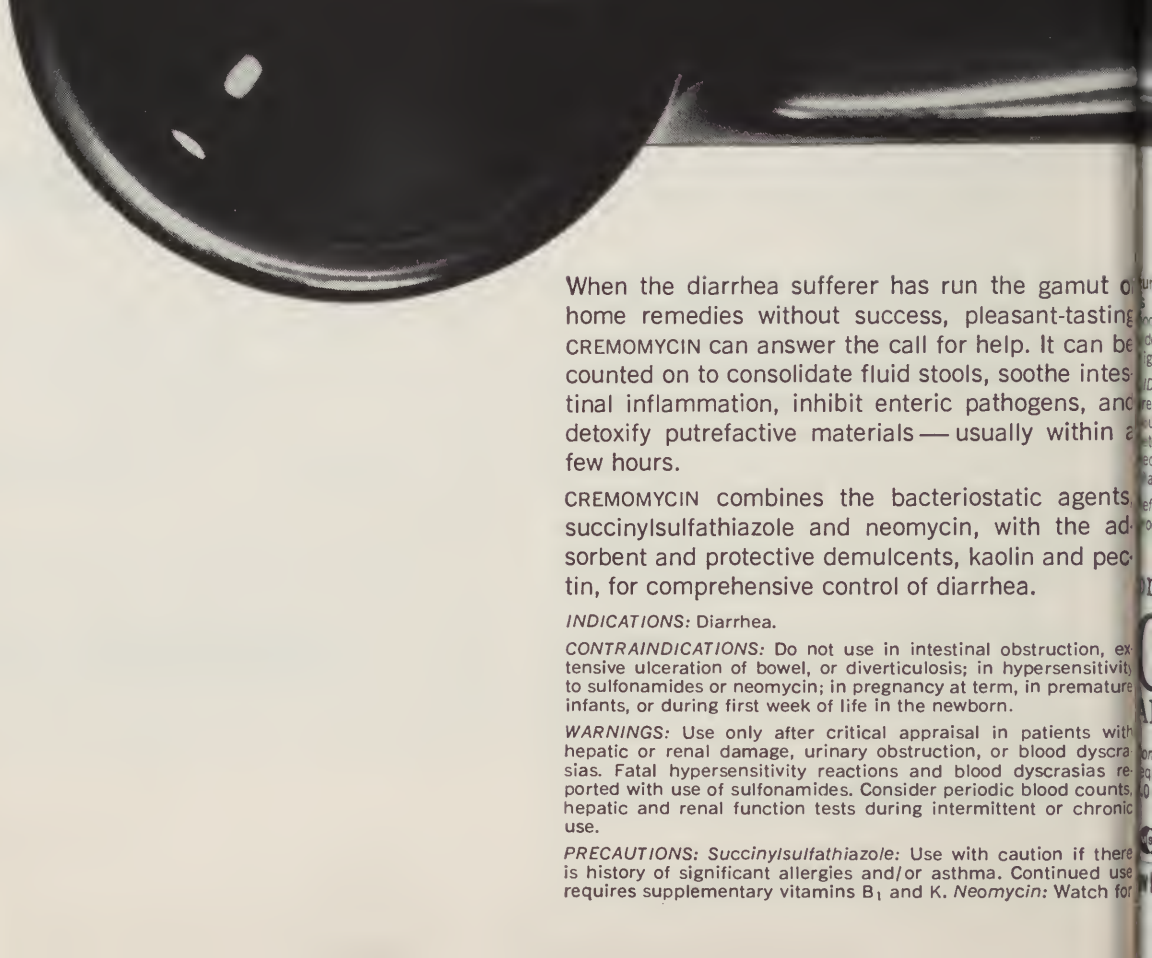
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BASIC CONSIDERATIONS IN THE CONSTRUCTION OF AN INTENSIVE CARE UNIT

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A 10-bed intensive care unit constructed in a 377-bed general medical and surgical hospital has demonstrated the advantages to every hospital of at least one such unit. The problems involved in the planning and installation of a unit are numerous, but can be readily solved with minimal effort and expense and with benefit to all concerned.

Treatment in an Intensive Care Unit, although frequently most appealing to personnel because of inherent activity, is nevertheless but one facet of total patient care. The creation of a good unit will automatically provide for progressive division of patients in a number of categories. Hospitals in the United States have adopted some of the care elements and before long will probably encompass all of them.

Total patient care epitomizes all that is best for both short- and long-term patients. Such care can be divided into five parts:

1. *Intensive care* for seriously ill patients who are concentrated in a single area under constant surveillance and with equipment for resuscitation immediately at hand.
2. *Intermediate care* for patients requiring a modicum of nursing care.
3. *Self care* for patients who require only diagnostic or convalescent facilities of the hotel type, and who can go to the dining room, canteen and moving picture theater.
4. *Long term care* for patients who have chronic brain syndrome, stroke or amputation.
5. *Home care* for patients who report to the hospital periodically until they are well or until their disease is stabilized.

An intensive care unit can provide services for any group of acutely ill medical and/or surgical patients, or for any subdivision in each of the categories. The size and the number of units needed depend upon the size of the individual hospital and the number and scope of patients' diseases. In large medical centers, for example, separate units can be created for patients with coronary occlusion, general surgical problems, and neurological diseases. That all hospitals should have at least one such unit has been demonstrated at the 377-bed Veterans Administration Hospital at Fort Howard, Md, where the installation and use of a single intensive care unit for the treatment of seriously ill medical and surgical patients has resulted in the improved treatment of patients in the unit and throughout the hospital.

Advantages

Isolated physically and functionally, the intensive care unit provides opportunities for uninterrupted nursing care and for a team approach on the part of physicians and nurses to the problems of the patient. Around-the-clock observation of patients and prompt treatment of complications reduce morbidity and mortality in any disease. Better use is made of equipment. Relatives are reassured that the patient is receiving the best possible care, and the hospital can provide it with minimal effort and expense.

Units need not be elaborate and expensive. Frequently the relocation of specialized equipment already owned by the hospital will serve as the nucleus for a unit. Nor is it true, as some people think, that a good unit must contain many of the currently advertised electronic devices, with an electronics expert in constant attendance to assure their proper operation.

Planning The Unit

The question of who plans the unit in the individual hospital can be answered in different ways. In many instances the director will take the lead, while in others the program will be initiated by those with a more direct interest in the care of the patient. In any event, the director should be the coordinator.

New construction is not always necessary since, frequently, an existing area can be adequately renovated. The details of physical features must be decided well in advance of construction. The type of patient will determine whether a large room or cubicles with one or more beds will serve the purpose better. Isolation units may or may not be considered necessary. The size of the unit will depend upon the hospital and the enthusiasm with which the major services enter the project.

The location of the unit may create a problem. If only one area is provided, it should be closest to the service with the greatest workload. The room should be away from heavy traffic, readily accessible to elevators, and near operating room, clinical laboratory, electrocardiographic department, department of roentgenology, and central service. Such an ideal situation usually cannot be found and therefore the site satisfying the majority of the criteria should be selected.

The number of beds required in the unit is also a problem. Statistics from other hospitals are in the formative stage and very often can only be used as a poor guide to what is necessary in a particular situation. In a 377-bed hospital which gives general medical and surgical care and in which the average daily patient load is 335, 10 beds were put in the intensive care unit. Experience has substantiated the wisdom of the estimate. If one large room is used, a distance of eight feet between bed centers should be allotted to provide room for care.

Physical Facilities

Provision of expert care and treatment of acute problems in an expeditious manner demand the presence of certain physical facilities. The basic needs are shown in the following list.

1. Because equipment for resuscitation is run by electricity, there should be four electrical outlets, as well as one wall light on flexible hinges, at the head of each bed. The outlets and good ceiling lights should be connected to an auxiliary power supply. Bluish ceiling lights give an odd tinge to the patient and should not be used.

2. One outlet for oxygen should be on the wall at the head of the bed, with the gas being supplied from a bank of cylinders in a remote region. An alarm system to signal the start of the use of the reserve supply and a shut-off valve for the whole system should be located in the unit. Oxygen is passed through a humidifier and administered by intranasal catheter. Tents present an extreme fire hazard and are never used.

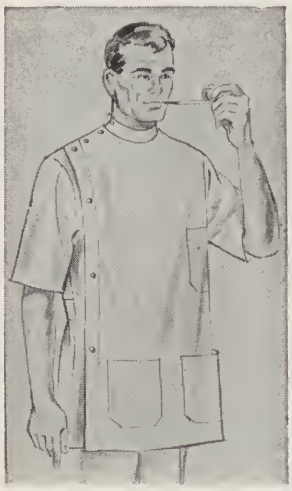
3. Suction is also provided through pipes in the wall and a double-arm distributor at each bed. One part of the unit gives a negative pressure of 200 mm of mercury for air-vent suction and 1-90 mm for gastrointestinal aspiration. The pressure on each side can be graduated. The collection bottles have a capacity of 2,000 ml and are fastened to the wall. The vacuum pump should be connected to the emergency power supply.

4. Beds are the only pieces of furniture. Any bed will serve satisfactorily, but the nursing personnel have found that beds which can be raised or lowered by an electric motor give the greatest convenience. Beds should have large casters and locks. Bedside tables and chairs are not needed. Seriously ill patients do not need personal articles in the unit. A fixed shelf between beds provides space for equipment. Each patient has a separate

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#303—100% Cotton Jean Twill **$3.99**

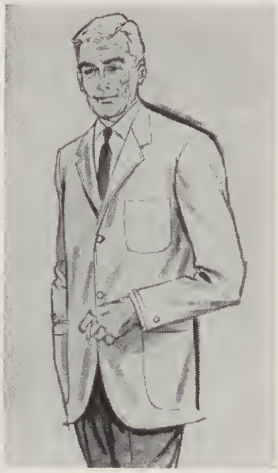
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5514—Tan. Sanf. Linene **$5.50**

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WOMAN'S LAB

310—Sanforized Twill Jean **$5.50**

3310—65/35 Dacro-Gab. **$8.99**

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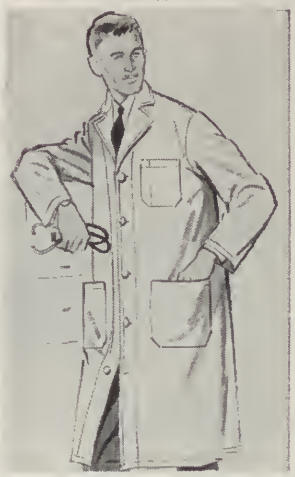
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wash basin which is hung on a hook under the shelf. Individual bed pans for each patient are not necessary because the few needed can be cleaned and sterilized in an adjacent room. The floor is kept completely free so that equipment necessary for patient use can be easily brought to the bed.

5. Divider curtains hanging from the ceiling provide the necessary privacy in acute clinical situations. At all other times, the curtains are swept back to the wall so that the patients can be observed constantly. Curtain dividers which rest on the floor inhibit free mobility.

6. A proper store room for supplies and equipment is an essential feature.

7. A small unit for bedpan and urinal cleaning should be located in an adjacent room. Adequate facilities for handwashing must be provided.

8. A communication system should be installed between the intensive care unit and the telephone operator of the hospital. In an emergency, nursing personnel can ask the telephone operator to summon help. After a determined hour in the evening, the system can be directly connected to the hospital page system so that a direct call for aid can be made.

9. A waiting room for relatives should be in close proximity to the intensive care unit. A speaker in the communication system should be placed there so that relatives may be summoned for visits.

10. The floor of the intensive therapy unit should not be conductive. Equipment does not need to be explosion-proof.

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11. The intensive care unit should be air conditioned.

12. Radio and television are not necessary.

Equipment

1. A cardiac monitor with an oscilloscope, audible and visual alarms, and an external and internal cardiac pacemaker is necessary. A defibrillator with a synchronizer should be a part of the apparatus.

2. A small and simple-to-operate respirator is mandatory. A valve-to-patient hose which can be connected to face mask, endotracheal tube, or tracheostomy tube, is used. Manual operation should be possible if electrical current failure occurs.

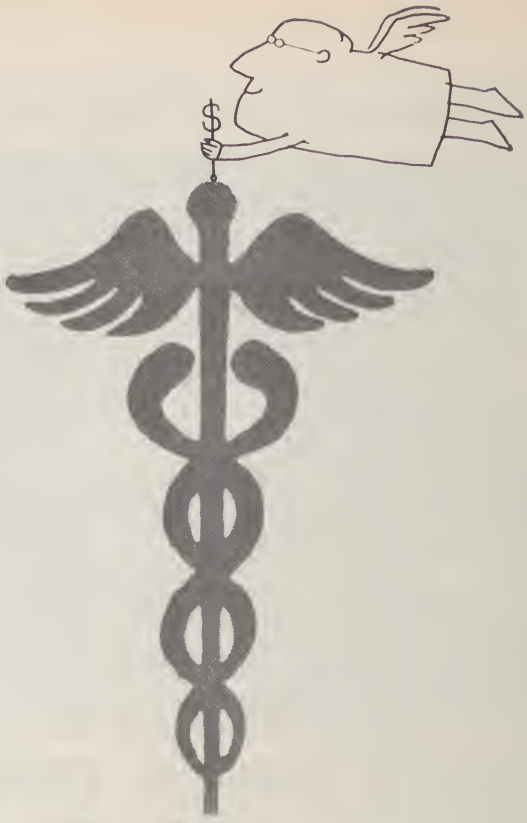
3. An electro-mechanical instrument for controlling body temperature should be part of the equipment. The need for such an instrument will vary according to the hospital but, even when the item may be considered a luxury, it should be purchased.

Patients Admitted

Patients admitted to the intensive care unit at the VA Hospital have come from the medical service and the surgical service. Admissions were confined to the following groups because patients requiring terminal care, having contagious diseases, or in a state of great excitement, were not admitted.

1. Medical Patients
   a. Cardiac disease
   b. Cerebrovascular accidents
   c. Coma
   d. Infectious diseases which were not contagious
   e. Renal disease
   f. Hepatic disease
2. Surgical Patients
   a. Major operations
   b. General anesthesia
   c. Head injuries
   d. Thoracic injuries
   e. Severe trauma
   f. Hemmorrhage

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LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

tackles the problem of diarrhea directly

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.

Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

• Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel • Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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SEMIANNUAL MEETING SEPTEMBER 9, 1966

MINUTES

The 255th meeting, semiannual session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:35 AM, Friday, September 9, 1966, at Ocean City, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance. The asterisk indicates an alternate delegate:

Doctors: Manning W. Alden, Council; John G. Ball, Montgomery County; Richard D. Bauer, Council; *E. I. Baumgartner, Garrett County; Harry McB. Beck, Baltimore County; Donald W. Benson, Baltimore City; M. McKendree Boyer, Past-president; Henry A. Briele, Council; Frank E. Brumback, Washington County; Wendell J. Burkett, Kent County; Read N. Calvert, Montgomery County; Robert vL. Campbell, Council; Douglas G. Carroll, Baltimore City; Robert G. Chambers, Baltimore City; *Katherine A. Chapman, Montgomery County; Henry V. Chase, Council; *David S. Clayman, Prince George's County; Archie R. Cohen, Council; H. Douglas Cooper, Wicomico County; Ernest I. Cornbrooks, Baltimore City; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore City; John B. DeHoff, Baltimore City; DeWitt E. DeLawter, Montgomery County; Everett S. Diggs, Council; J. Sheldon Eastland, Council; William Carl Ebeling, Council; Robert W. Farr, Council; James McC. Finney, Harford County; Russell S. Fisher, Council; Harold H. Gist, Washington County; *Edward G. Grau, Baltimore County; *Paul F. Guerin, Baltimore County; William B. Hagan, Council; John C. Harvey, Baltimore City; Thomas F. Herbert, Howard County; Philip W. Heuman, Harford County; *H. Logan Holtgrewe, Anne Arundel County; James P. Jarboe, St. Mary's County; William T. Joyce, Montgomery County; Ferd E. Kadan, Baltimore City; James R. Karns, Baltimore City; Lauriston L. Keown, Baltimore City; Howard F. Kinnamon, Past-president; Henry P. Laughlin, Council; *Eugene J. Linberg, Baltimore City; F. Ford Loker, Baltimore City; George S. Malouf, Prince George's County; Karl F. Mech, Council; Philip W. Mercer, Carroll County; Walter C. Merkel, Board of Medical Examiners; B. Martin Middleton, Council; John E. Miller, Baltimore City; Donald W. Mintzer, Baltimore City; Andrew C. Mitchell, Wicomico County; Howard T. Morse, Montgomery County; *F. E. Musser, Prince George's County; Clayton Norton, Anne Arundel County; Charles F. O'Donnell, Council; *Theodore C. Patterson, Baltimore County; A. Austin Pearre, Past-president; William A. Pillsbury, Council; *Carolyn S. Pincock, Montgomery County; J. Emmett Queen, Council; Belden R. Reap, Sr., Montgomery County; J. Morris Reese, Council; Guy M. Reeser, Jr., Talbot County; Thomas R. Reid, Frederick County; Paul F. Richardson, Baltimore City; Raymond C. V. Robinson, Baltimore City; Donald J. Roop, Council; Edwin R. Ruzicka, Talbot County; *William J. Rysanek, Jr., Baltimore City; Emmanuel A. Schimunek, Baltimore City; Thaddeus C. Siwinski, Baltimore County; Aaron C. Sollod, Baltimore City; *William G. Speed, III, Baltimore City; Omar D. Sprecher, Jr., Washington County; Martin E. Strobel, Baltimore County; E. L. Suarez-Murias, Baltimore City; *Ivory U. Sully, Jr., Worcester County; Thomas E. VanMetre, Jr., Baltimore City; Merton T. Waite, Anne Arundel County; Emerson Walden, Baltimore City; J. Arthur Weinberg, Council; *William C. Weintraub, Prince Georges County; Eldridge H. Wolff, Dorchester County; *Charles E. Wright, Frederick County; Raymond M. Yow, Council; Walter N. Kirkman, Council.

Present also for the meeting were staff personnel.

The President made certain announcements with regard to the conduct of business at the session.

The minutes of the April 26 and April 29, 1966 meetings respectively of the House of Delegates, annual session, having been distributed to the members, and having been approved by the Executive Committee, were presented to the House for information.

EMERITUS MEMBERSHIP

On the recommendation of the Council, the following member was elected to Emeritus Membership:

Victor Goldberg, MD, Baltimore City

MEDICOLEGAL COMMITTEE REPORT

Howard F. Kinnamon, MD, Chairman of the Medicolegal Committee, on its behalf, moved adoption of the following amendments to the Medicolegal Code of Cooperation, such amendments having already been adopted by the Baltimore City Bar Association and the Maryland State Bar Association, which, after debate were adopted:

MEDICAL EXAMINATIONS AND REPORTS

2. REPORTS TO PATIENT OR HIS ATTORNEY:

The patient, or his attorney, upon written request, when accompanied by a signed authorization from the patient, shall be entitled to a prompt report from an attending physician, containing the history, physical condition, diagnosis and prognosis, but not including an evaluation of disability. The physician's fee for such report should be commensurate with the time and effort devoted to its preparation.

PROPOSED PARAGRAPH FIVE

5. REFERRALS BY ATTORNEYS:

Attorneys are cautioned not to refer a patient under treatment to another physician for examination, consultation or treatment without the knowledge of the physicians involved. The physician to whom the patient is referred may be guilty of a breach of ethics if he accepts a patient for examination, consultation or treatment without the knowledge of the treating physician.

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*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



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Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

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FACULTY DELEGATES TO THE AMA REPORT

The report of the Faculty's Delegates to the American Medical Association was filed.

BUILDING COMMITTEE REPORT

Dr. Pillsbury, Secretary, on behalf of the Building Committee, moved adoption of the following motion which was unanimously passed:

> That the Building Committee be dissolved and the control of the funds presently held in the committee be transferred to the Treasurer in accordance with Article III, Section 10, of the Bylaws; such funds to be held in separate Building Fund accounts.

REFERENCE COMMITTEE REPORT

Dr. Diggs, on behalf of the Reference Committee, reported to the House with respect to Resolution 1S/66, and recommended that it not be adopted.

RESOLUTION 1S/66 REJECTED AS AMENDED

After debate and amendment, the House rejected Resolution 1S/66, as amended, which read as follows:

Whereas, The Medical Practice Act of the State of Maryland is interpreted as precluding the Corporate Practice of Medicine; and

Whereas, No adequate substitutes for the current methods have been forthcoming that will provide the same level of teaching cases for medical students, interns and residents; therefore be it

Resolved, That this body instruct the Legislative Committee, in conjunction with the Faculty's legal counsel, to communicate with the proper State Legislative body and propose a bill to amend the Medical Practice Act to allow such "Corporate Practice," in said hospitals.

RESOLUTION 2S/66 ADOPTED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 2S/66 be adopted.

After debate, the House adopted Resolution 2S/66, which read as follows:

Whereas, The physician has more paper work than is good for him; and

Whereas, The trend of good medical practice is toward more and more laboratory procedures and insurance work; and

Whereas, The requisitions of the Maryland State Department of Health, Bureau of Laboratories; as well as many Insurance Companies, are unnecessarily cumbersome; be it

Resolved, That the Faculty's Liaison Committee review requisition forms of the Maryland State Department of Health, Bureau of Laboratories; Insurance Companies; and Blue Cross and Blue Shield; so as to recommend elimination of unnecessary detail; and be it

Resolved, That such Committee hold hearings where the affected physicians could voice their grievances and make appropriate recommendations.

RESOLUTION 3S/66 REJECTED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 3S/66 be NOT adopted.

After debate, the House rejected Resolution 3S/66, which read as follows:

Whereas, Current medical and lay opinion deems it the responsibility of every physician to practice preventive medicine and screen for the earliest signs of curable disease; and

Whereas, The scope of the Maryland Public Health Laboratory, as defined in Section 35, Article 43, Annotated Code of Maryland, 1965 Supplement, is ". . . to provide laboratory services in screening or surveillance;" and

Whereas, The Commissioner of Health has seen fit on April 18, 1966, to define screening programs as "planned studies, within identifiable population groups toward the detection in early stages of diseases in presumably well people," and to rule, "That test specimens taken by practitioners are not at the present time to be part of the departmental screening program;" therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland considers arbitrary and unlawful the Commissioner of Health's exclusion of the practicing physician's screening activity from the benefits of the Maryland State Department of Health Laboratory Services, and that the Faculty use its offices to persuade the Commissioner of Health to rescind this part of his directive.

RESOLUTION 4S/66 ADOPTED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 4S/66 be adopted.

After debate, the House adopted Resolution 4S/66 which read as follows:

Whereas, There is an increasing demand on the part of the health insurance-buying public for the full coverage of fees for professional services; and

Whereas, The implementation of the Medicare Program will undoubtedly further increase the demand for such coverage; and

Whereas, Fee schedules for paid-in-full programs tend to become obsolete as the economy rises; and

Whereas, Most physicians in private practice feel strongly that the most appropriate way to provide such coverage, on an insured basis, is through the medium of programs that make payments for professional services on the basis of reasonable and customary fees for covered services; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urge the Maryland Blue Shield Plan to develop without delay a program whereby professional fees will be covered on the basis of reasonable and customary charges; and that such program, when developed, be sold as widely as possible to the end that it may supersede existing scheduled fee programs to the greatest extent practicable.

RESOLUTION 5S/66 ADOPTED AS AMENDED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 5S/66 be adopted.

The House, after debate and amendment, adopted Resolution 5S/66, which read as follows:

Whereas, The passage of Public Law 89-97, commonly known as the Medicare Act, amends the Social Security Act by creating, under Title XVIII, a program of Health Insurance for the Aged, and, under Title XIX, a program of Grants to States for Medical Assistance Programs; and

Whereas, Under both programs it is the clear intent of the Congress that payment for care provided thereunder shall be on the basis of reasonable cost or charges; and

Whereas, Under Title XIX of Public Law 89-97, the State and Federal Governments are jointly responsible for paying the reasonable cost of the provision of medical care for disadvantaged persons; and

Whereas, Government's assumption of the cost of such care removes the beneficiaries under such programs from the medically indigent category; and

Whereas, It is not the intent of Public Law 89-97 to interfere in any way with the close personal relationships between beneficiaries and their physicians, nor to adversely affect the quality of medical care because of inadequate financing of the cost of such care; and

Whereas, It has been clearly demonstrated in the Military Dependents Medical Care Program that average payments for professional services have been consistently lower in those areas in which such payments have been made on the basis of usual, customary and reasonable charges, without published fee schedules, than in those in which published fee schedules were used; now therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland, representing the practicing physicians in Maryland, develop immediately with the Maryland State Department of Health a program of health care for the disadvantaged,

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



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Each chewable tablet contains: nicotinic acid (niacin) 75 mg. and aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

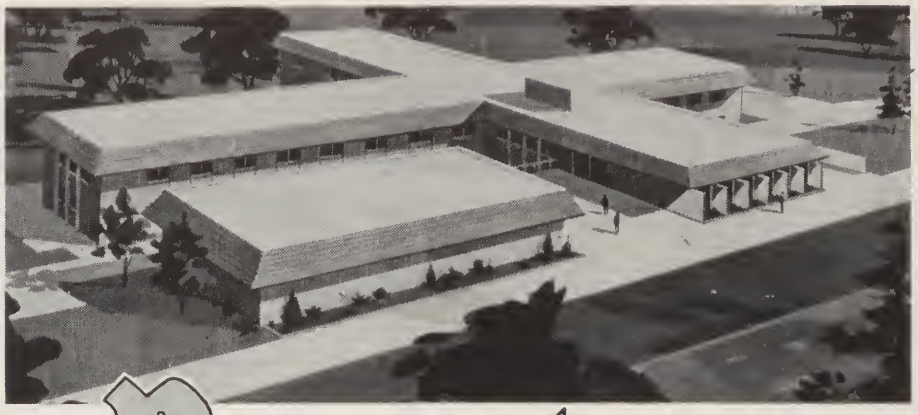
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Professionally staffed and equipped Physical Therapy gymnasium, under the direct supervision of a specialist in physical medicine. There is also an organized program of recreation.

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under the provisions of Title XIX of Public Law 89-97, under which all payments for professional services shall be on the basis of usual, customary and reasonable charges; and be it further

Resolved, That, effective immediately, all physicians be urged to bill at their usual customary and reasonable fees in order that the Health Department be aware of the extent to which physicians are now subsidizing the Medical Care Program, even though it is recognized that payments must, perforce, be made on the basis of current budgeted funds; and be it further

Resolved, That copies of this resolution be sent to the Governor of the State of Maryland, the Budget Bureau of the State of Maryland, the Maryland State Board of Health and Mental Hygiene, and the Commissioner of Health of the State of Maryland.

RESOLUTION 6S/66 ADOPTED AS AMENDED

Dr. Diggs, on behalf of the Reference Committee, recommended that Resolution 6S/66 be adopted.

The House, after debate and amendment, adopted Resolution 6S/66 which read as follows:

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37 (c), reads as follows:

> "All fees and other charges for such treatment and services shall be subject to regulation by the Commission, and shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.";

Whereas, The trend today is toward payment of the physician's usual, customary and reasonable fees; and

Whereas, Hospitals throughout the State are permitted to bill Carriers or others on the basis of their posted charges, without obtaining permission for any increases in such charges; now, therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for professional services rendered Workmen's Compensation Cases, as well as all other Governmental agencies.

OPPOSITION TO COMPULSORY ASSESSMENT OF HOSPITAL STAFF MEMBERS

Dr. Rysanek presented the following resolution for consideration of the House of Delegates. On more than a two-thirds vote, it was agreed to consider it and it was adopted as follows:

Resolved, That this House of Delegates go on record as being in opposition to the *compulsory assessment* of hospital staff members for hospital construction or equipment.

LEGISLATIVE CHAIRMAN REPORT

Dr. Middleton, Legislative Chairman, addressed the House and asked for assistance and cooperation when the 1967 Legislature convenes whenever the members may be called upon.

MEDIC NETWORK APPROVED

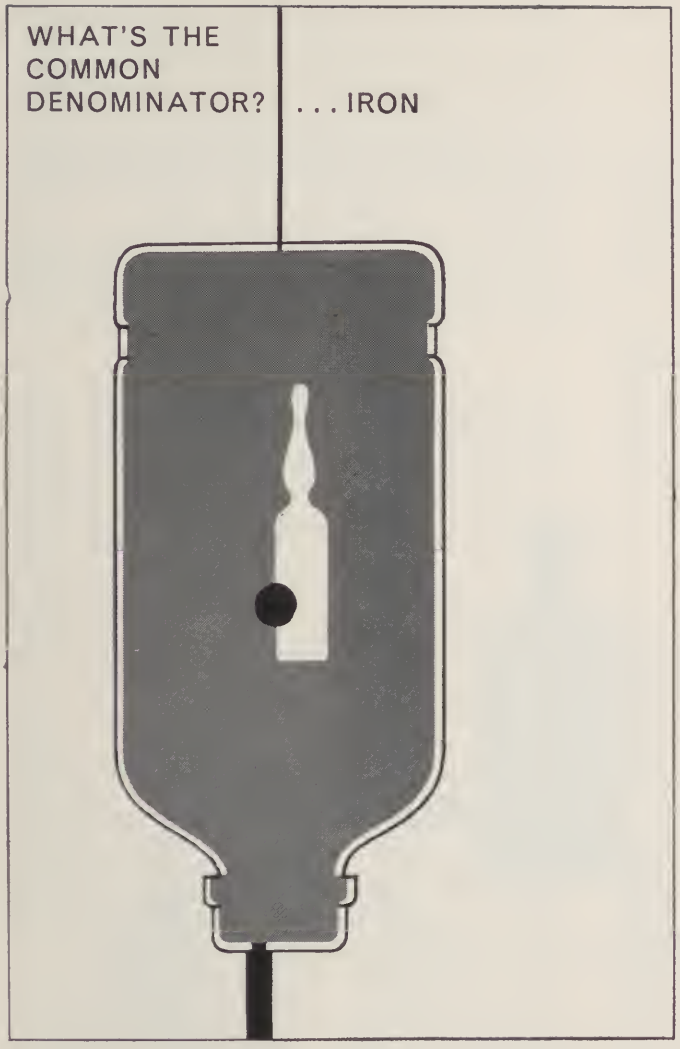
Dr. Mech, Treasurer, presented the following motion for adoption by the House which, after debate, was adopted as follows:

Resolved, That the Medic Network be approved for the 1967 calendar year.

There being no further business, the President made several announcements, following which the House, by unanimous consent, adjourned *sine die* at 11:25 AM.

WILLIAM A. PILLSBURY, MD, SECRETARY

In fact, there's as much iron...250 mg. ...in a 5 cc. ampul of Imferon (iron dextran injection) as in a pint of whole blood. When iron deficient patients are intolerant of oral iron...or orally administered iron proves ineffective or impractical...or if the patient cannot be relied upon to take oral iron as prescribed, Imferon (iron dextran injection) dependably increases hemoglobin and rapidly replenishes iron reserves.



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(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb/100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. Initial test doses are advisable. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylatoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

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SEMIANNUAL MEETING
September 9, 1966

REPORTS

To the House of Delegates

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

HOUSE OF DELEGATES MEETING, JUNE 26-30, 1966, CHICAGO, ILL.

As was to be expected, Medicare and its impact on the practicing physician was high on the agenda for consideration when your delegates attended the 115th annual session of the American Medical Association. In the first night session for more than 10 years, the House met to discuss various Reference Committee reports, make amendments to them, and adopt them as amended. A summary of the actions taken at this meeting follows. When appropriate, material has been disseminated to committees of the Faculty for their action.

Medicare

In accepting and commending a Board of Trustees report on Medicare, the House recommended that "the Association give wide dissemination to the information contained therein, particularly its informed discussion of direct billing, the basic purposes of utilization review, the rejection of compensation for service on such committees except in exceptional circumstances, and the proper placement of any onus of responsibility for any failure in the Medicare program."

The Board report ended with the following conclusion:

During the past year many individuals have represented the American Medical Association and the physicians of the United States by meeting frequently with officials of the Department of Health, Education and Welfare. This degree of cooperation on our part should be viewed as a recognition by responsible citizens of an obligation to obey the law of the land, including this law with which we disagree. Our specific purposes have been to provide expert assistance to the government so that this law could be implemented in a manner most helpful to the beneficiaries while disturbing the practice of medicine to the minimum degree. Despite our best efforts, it is apparent that serious problems are inevitable in connection with the implementation of this law, and we trust that the physicians and the public will place the blame for such deficiencies squarely where they belong—on the federal government.

We are proud of the role we have assumed, and in many instances our efforts have been productive. Proposed forms were simplified; some unnecessary forms eliminated, and a number of our suggestions was incorporated in regulations and procedures. An informative "Reference Guide" for physicians, recently distributed, was prepared with consultation of AMA staff. Numerous other items will continue to receive our most serious study and consideration, and the Board urges and requests that every member exhibit his personal diligence by supplying his local medical society documented evidence of transgressions of the spirit or the letter of the law as it is implemented.

The Board of Trustees intends to continue to supply advice, guidance, and dissent when necessary to the Government or to other third parties on matters that pertain to the health of the public and the interests of the medical profession.

The House strongly supported the general concept of individual responsibility and endorsed a report from the Council on Medical Service which included the following statement:

Since the Council believes that the current interest in the doctrine of individual responsibility stems in large part from concern over the matter of assignments under PL 89-97, it hastens to add that, as a matter of American Medical Association policy, the Council on Medical Service recommends reaffirmation of the responsibility of individual physicians for determining how they will govern their professional practices under this law and that physicians should be made acutely aware of the manifest superiorities of direct billing as previously communicated to this House in the Council's Report E (A-66) on "Recommendations on the Physician's Role in Medicare."

The latter report (Report E) was highly commended, and the House recommended its widest possible dissemination, including publication in its entirety in a prominent place in the earliest possible issue of *AMA News*.

Physicians' Billing Procedures

In connection with the Medicare part of Public Law 89-97, the House also adopted three resolutions which recommended that physicians use the direct billing method rather than the assignment procedure. At the same time, the House pointed out that adoption of these resolutions should not be interpreted as contravening the statement approved at the Special Session in October, 1965, which said:

The American Medical Association opposes any program of dictation, interference or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

In considering a resolution on the right to bill patients under Title 19 of the law, the House passed an amendment pointing out that direct billing has been recommended as the billing method of choice under Title 18 by the Board of Trustees and the Council on Medical Service. It then said that since there is a wide latitude available to the states in establishing administrative procedures under Title 19, each state medical association should work early and diligently in its own state so that any plan or law adopted in its state for approval under Title 19 would include authorization for direct billing.

The House also instructed the AMA Advisory Committee to the Department of Health, Education and Welfare to do all in its power to implement the intent of the resolution at the national level. In addition, the House urged positive steps to obtain statutory authority for a continuing medical advisory committee under Title 19, and it called on the AMA and the state societies to maintain added vigilance to eliminate any patterns which might subvert the intent of Title 19.

Hospital-Based Physicians

The House passed two resolutions involving billing and reimbursement principles affecting hospital-based specialists but also of significance to all physicians. The first said:

The *Principles of Medical Ethics* declare that a physician

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides.* Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day.*



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(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

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shall not dispose of his services to a third party or "lay" organization, and

Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations, and

A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle; therefore be it

Resolved, that, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing.

The second resolution regretted that publication of Medicare Regulations #5 (which provides for reimbursement of hospital-based physicians and establishes rather stringent rules that would "lock" physicians into their present arrangements) was delayed until June 28, three days before the effective date of Medicare, and said that these regulations do not conform to the intent of Congress as expressed in Section 1801 of the Medicare law. It then declared that:

The House of Delegates instruct the Board of Trustees and the Executive Vice President to request from the Social Security Administration an extension of date of final adoption of the proposed regulations of not less than 90 days, in order that the American Medical Association and all other interested medical organizations be allowed reasonable time to study, and to submit to the Social Security Administration, data, views or arguments and pertinent constructive comments and suggestions.

To preserve the professional independence of medical practice that the Board of Trustees and Officers of the AMA be instructed to immediately inform the membership that Medicare Reg. #5 will not apply to physicians (whether hospital-based or not) who

1. have no financial relationship with a hospital covering medical services to patients
2. do not accept assignments but bill directly

The AMA News and other appropriate media be used to advise all physicians who are developing contractual relationships with hospitals for professional service that they should delay the finalization of any agreements pending further analysis of the implementing regulations.

Medical Ethics

In acting upon a Board of Trustees recommendation that a physician may participate in the ownership of a pharmacy or regularly dispense drugs, remedies or appliances or provide eyeglasses to his patients *only when approved by his component and constituent medical associations and when it is determined by them to be necessary in the best interests of the patient,* the House approved the following reference committee statement:

The *Principles of Medical Ethics* provide: "Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient." Your reference committee reaffirms the 1963 House of Delegates interpretation of the words "in the best interest of the patient," which reads as follows:

"It is the opinion of the Judicial Council that this language was adopted to permit both the practicing physician and the local medical societies to evaluate the many factual situations incident to prescribing and dispensing which are bound to arise in the practice of medicine. Under this language the doctor is permitted to exercise his own best judgment when caring for his patient It is known that there will be situations when it is necessary or desirable for a physician to dispense or supply what he has prescribed. The *Principles* permit this to be done. On the other hand, this broad language provides a means by which a component medical society can inquire into the facts of a particular practice. The profession thus can act to prevent abuse of discretion and protect patients from exploitation. In essence this language means that a physician in the exercise of sound discretion may dispense 'in the best interest of his patient'; it does not authorize him to dispense solely for his convenience or for the purpose of supplementing his income."

The reference committee approves the goals sought by the Board's report but disapproves its specific recommendations. It notes that mechanisms presently exist for processing charges of deviation from the foregoing ethic and urges that these mechanisms be made vitally active at local level. When charges of deviation develop, complaints should be made to the local society and vigorously processed by the appropriate committee of that society. If they are not resolved thereby, the complaints should then be carried to the state constituent association. The prudent physician will always seek the guidance of his local medical society in situations relating to ethical conduct.

The House directed the Board of Trustees to take action as expeditiously as possible to give wide dissemination to the reference committee report.

Discrimination

The House received six resolutions dealing with discrimination against some applicants for membership in component medical societies. It called attention to the strong position taken by the House in 1964 but pointed out that it is difficult to follow the 1964 directive because there is now no mechanism at the national level whereby a rejected applicant for membership at county or state level may obtain a hearing in order to right an alleged wrongful discrimination.

In lieu of the six resolutions, the House adopted a substitute resolution which directed the Council on Constitution and Bylaws to prepare such changes in the Constitution and Bylaws, "as may be necessary to permit the Judicial Council to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in a local and/or state society." The House asked the Council to report its recommendations at the 1966 Clinical Convention.

Health Manpower

On the subject of health manpower the House received reports from the Board of Trustees, Council on Medical Education and Council on Medical Service and also one resolution. In general, all of them urged the AMA to assume leadership and mobilize its efforts to meet present and future shortages in health manpower. The House approved the Board report, announcing appointment of a Committee on Health Manpower, and adopted the resolution. The two Council reports were referred to the new Board committee.

In taking these actions, the House approved a reference committee statement which included the following:

Your Reference Committee is well aware of the drastic shortage of health manpower that is confronting the American public. It is keenly appreciative of the opportunity presented to the American Medical Association to furnish leadership in the solution of this problem. The necessary additional manpower in the medical profession and in allied health professions must be developed. The most effective and efficient utilization of existing health manpower must be made at all times. This is no time to surrender leadership to persons or organizations outside of the medical profession.

AMA Dues Increase

By a vote of 168 to 46, the House approved an increase in AMA annual dues from $45 to $70, effective January



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

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Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

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1, 1967, thus confirming a Board of Trustees recommendation which was given initial approval at the 1965 Clinical Convention.

The House, in approving the dues increase, accepted a reference committee statement which said:

It is quite apparent that the programs necessary to serve the needs of the members of the Association cannot be conducted effectively without adequate financing and it is equally apparent that such adequate financing is impossible without the dues increase requested by the Board of Trustees. Your Reference Committee reaffirms its confidence in the judgment of the Board of Trustees which has in the past and must in the future exercise the most careful and prudent stewardship over the assets of the Association. The Board of Trustees is the Committee elected by the House of Delegates to investigate and control the finances of the Association. The appointment of any other committee to perform this function would be most inappropriate

Other Actions

In considering 106 resolutions, 38 board reports and at least 20 additional reports from councils and other groups, the House of Delegates also:

Endorsed the *Declaration of Helsinki*, already adopted by the World Medical Association, as a guide to those who are engaged in clinical medical investigation;

Reaffirmed its opposition to the *compulsory assessment* of hospital staff members in order to raise funds for hospital construction;

Reconsidered its action in defining *usual, customary and reasonable* fees and referred the matter back to the Council on Medical Service for further study;

Urged all state and county medical societies to send representatives to the *Third National Congress on Medical Quackery* to be held October 7-8, 1966, in Chicago;

Commended the *American Medical Association Education and Research Foundation* for its accomplishments during the past four years and gave a standing vote of gratitude to Dr. Raymond M. McKeown, AMA-ERF president since 1962;

Strongly endorsed the *AMA Volunteer Physicians for Vietnam* program and urged the entire profession to support it by word and deed; approved a recommendation by the AMA survey team and the Board of Trustees that the Association organize and administer a program of American assistance in *medical education in South Vietnam* supported by the U.S. Agency for International Development; was impressed by a report from Dean Pham Bieu Tam of the Faculty of Medicine, *University of Saigon,* and urged that the AMA do everything possible to assure that volunteer physicians caring for the South Vietnam civilian population are properly supplied with medicines and other *medical supplies;*

Adopted a resolution urging constituent medical associations to oppose, as detrimental to the public interest, any proposed legislation that would authorize *optometrists* to engage in the diagnosis or treatment of disease or injury of the eye;

Approved, with minor editorial revisions, a final report from the Committee on Maternal and Child Care of the Council on Medical Service dealing with the medical care aspects of *"Combating the Problems of Unwed Parents";*

Agreed with a strong policy statement condemning the *abuse of LSD* and other non-narcotic drugs, pointing out that the illicit use of LSD is subverting and vitiating important and necessary valid experimental studies, and recommending that the manufacture and distribution of LSD be continued as needed under strict control, with the drug being made available only to competent research workers (physicians trained in its use) on approval of the Department of Health, Education and Welfare;

Reaffirmed its opposition to the compulsory regulation of any *single* method, such as the use of generic terms, of the *prescribing of drugs;*

Offered AMA cooperation, in order to prevent public fear and misunderstanding, to those *foundations and other groups* which request it in clarifying statistical data, visual media and other forms of medical information to be presented to the public so as to provide an accurate view of the problems or problem with which they are concerned;

Adopted a humorous resolution and an equaliy humorous reference committee report which requested that "in the future full air-conditioning be considered as a prerequisite in the selection of the headquarters hotel for the annual AMA Convention in those cities where the *psychophysiological effects of heat* may interfere with effective delegatemanship";

Received as information a comprehensive report on the *Relation of Medicine and Osteopathy,* which contains much material pertinent to future policy considerations, and also approved in principle a recommendation that doctors of osteopathy be commissioned in the *Armed Forces Medical Services;*

Agreed with a report recommending that the core curriculum plan for continuing medical education be *not* approved in its present form, that no further core curricula be developed at this time, and that various methods of continuing medical education be studied under the auspices of the Council on Postgraduate Programs;

Expressed its opposition to the *Hart bill,* S. 2568, and all similar legislation;

Adopted reports from the Council on Medical Service on a *Model Emergency Department Agreement* and on *Multiple Coverage in Voluntary Health Insurance;*

Approved Board reports on *Exercise and Physical Fitness,* encouraging state and local medical societies to support the promotion of fitness programs, and on *Venereal Disease Control,* emphasizing the continued need for all physicians to report all cases that come to their attention, and

Authorized the Speaker of the House to appoint a *Resolutions Consultation Committee,* purely for editorial advisory purposes, at subsequent AMA conventions.

Attendance

All three of the Faculty's delegates attended all business sessions of the House. In addition, the senior alternate delegate and another alternate delegate, Charles F. O'Donnell, MD, were present.

Respectfully submitted,
Robert vanL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD
William B. Hagan, MD,
Senior Alternate Delegate

BUILDING COMMITTEE

Mr. President and Members of the House of Delegates:

This committee has been relatively inactive during the past few years, since the completion of the building renovations. In view of this fact, the committee recommends:

That the Building Committee be dissolved and the control of funds presently held in the committee be transferred to the Treasurer in ac-

When depressed patients say:



"I can't sleep at night"



"I'm tired all day long"

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ANTIDEPRESSANT

helps restore normal patterns of sleep and activity

Norpramin (desipramine hydrochloride) often reverses the signs and symptoms of depression including sleep disturbances feeling of sadness, guilt, anxiety, worthlessness and bodily complaints without physical basis. In 2-5 days most patients become more hopeful, active and less weighed down by their problems.

Norpramin (desipramine hydrochloride) has only slight sedative qualities, nevertheless sleep disturbances and restlessness are relieved as depression is lifted. If anxiety or tension develop or persist a tranquilizer may be added or dosage reduced. Side effects are usually mild, occurring in about 1 of 4 patients.

Indications: In moderate to severe depression—neurotic or psychotic. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of an MAO inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste", sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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cordance with Article III, Section 10 of the Bylaws; such funds to be held in separate Building Fund accounts.

Respectfully submitted,
ALBERT E. GOLDSTEIN, MD* *Chairman*
EVERETT S. DIGGS, MD
E. W. DITTO, JR., MD
J. SHELDON EASTLAND, MD
R. WALTER GRAHAM, MD
WILLIAM B. LONG, MD
C. HERBERT MUELLER, MD
CHARLES F. O'DONNELL, MD
JOHN W. PARSONS, MD
AUSTIN B. ROHRBAUGH, MD

*Deceased

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The Medicolegal Committee presents the following amendments to the Code of Cooperation between the Maryland State Bar Association and the Baltimore City Bar Association, as adopted by this House in September, 1964.

Both the Baltimore City Bar Association and the Maryland State Bar Association have adopted these proposed amendments.

MEDICAL EXAMINATIONS AND REPORTS

AMENDMENT TO PARAGRAPH TWO

2. *Reports to Patient or his Attorney:* The patient or his attorney, upon written request, when accompanied by a signed authorization from the patient, shall be entitled to a prompt report from an attending physician, containing the history, physical condition, diagnosis and prognosis, but not including an evaluation of disability. The physician's fee for such report should be commensurate with the time and effort devoted to its preparation.

PROPOSED PARAGRAPH FIVE

5. *Referrals by Attorneys:* Attorneys are cautioned not to refer a patient under treatment to another physician for examination, consultation, or treatment without the knowledge of the physicians involved. The physician to whom the patient is referred may be guilty of a breach of ethics if he accepts a patient for examination, consultation, or treatment without the knowledge of the treating physician.

Respectfully submitted
HOWARD F. KINNAMON, MD, *Chairman*
CONRAD ACTON, MD
JAMES G. ARNOLD, JR., MD
RUSSELL S. FISHER, MD
ROBERT W. JOHNSON, III, MD
J. ELLIOT LEVI, MD
F. FORD LOKER, MD
JAMES A. MEATH, MD
BELDEN R. REAP, MD, LLB
EDWIN RUZICKA, MD
WILLIAM G. SPEED III, MD
JOHN F. STRAHAN, MD

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met on Thursday, July 28, 1966, to discuss the resolutions referred to it and which are to be considered by the House of Delegates on September 9, 1966. The committee was pleased with the excellent attendance at the session and was encouraged by the interest and discussion that took place.

As has been the custom, your Committee will recommend action to the House. The question, however, will be on the resolution itself and not upon the committee report. All decisions were reached in accordance with the Faculty's Bylaws, Article XI, Section 24.

RESOLUTION 1S/66

Submitted on:	March 3, 1966
Introduced by:	St. Mary's County Medical Society
Subject:	Changes in the Medical Practice Act to Permit Hospitals Associated with Medical Schools to Practice Medicine

Whereas, The Medical Practice Act of the State of Maryland is interpreted as precluding the corporate practice of medicine; and

Whereas, It is generally interpreted by the medical profession that those hospitals associated with medical schools are, in fact, engaged in the "corporate practice of medicine"; and

Whereas, No adequate substitutes for the current methods have been forthcoming that will provide the same level of teaching cases for medical students, interns, and residents; therefore be it

Resolved, That this body instruct the Legislative Committee, in conjunction with the Faculty's legal counsel, to communicate with the proper state legislative body and propose a bill to amend the Medical Practice Act to allow such "corporate practice" in said hospitals.

This resolution suggests that legislative changes be drafted to approve or condone what is now taking place. This would, therefore, be on the assumption that what is taking place at the present time is illegal. No court decision has ever been handed down to this effect. The Attorney-General's office has repeatedly indicated its unwillingness to reach or render an opinion in this area.

You can find as many proponents of the fact that what is being done is legal as you can opponents. Drafting such a proposed change in the law would be extremely difficult, if not impossible. If such a change were feasible and were adopted by the legislature it would then be subject to various interpretations through court action. It probably would not clarify the situation as it now exists and, in fact, might confuse the current wording of the Medical Practice Act which provides exemption from licensure for certain categories of physicians:

Nothing herein contained shall be construed to apply to . . . any resident or assistant resident physicians or interns or students at hospitals in the discharge of their hospital or dispensary duties.

In addition, it is our understanding that certain medical students, residents, interns, etc., perform part of their postgraduate work in practicing physicians' offices. How would such a change affect these arrangements?

Your Reference Committee, therefore, does not see how this situation can be clarified in a simple, understandable manner. **In the light of this, it recommends that this resolution not be adopted.**

RESOLUTION 2S/66

Submitted on: April 22, 1966

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Introduced by:	George Vash, MD
Subject:	Liaison Committee to Screen all Requisition Forms of Maryland State Department of Health, Bureau of Laboratories, Insurance Companies, and Blue Cross and Blue Shield, so as to Recommend Elimination of Unnecessary Detail

Whereas, The physician has more paper work than is good for him; and

Whereas, The trend of good medical practice is toward more and more laboratory procedures and insurance work; and

Whereas, The requisitions of the Maryland State Department of Health, Bureau of Laboratories, as well as many insurance companies, are unnecessarily cumbersome; be it

Resolved, That the Faculty's Liaison Committee review requisition forms of the Maryland State Department of Health, Bureau of Laboratories, Insurance Companies, and Blue Cross and Blue Shield, so as to recommend elimination of unnecessary detail; and be it

Resolved, That such committee hold hearings where the affected physicians could voice their grievances and make appropriate recommendations.

The general intent of this resolution is good. The form referred to in the third Whereas, with respect to the State Health Department's Bureau of Laboratories, was, in fact, approved by the Faculty's Liaison Committee and several modifications made in it.

The Faculty's House of Delegates in April, 1959, approved a "Simplified Insurance Claim Form." The American Medical Association and the Health Insurance Council also have been active in development of simplified forms. The recently developed Medicare claim form is an example of what can be accomplished in the way of simplicity and condensation of information needed for the processing of claims.

It would seem that the Faculty's Liaison Committee could provide a forum where aggrieved physicians could air their feelings and suggestions for improvements in claim forms. It would also enable an exchange of opinions to be entered into between those making payment under the claims and those who are required to complete such forms.

The Reference Committee, therefore, recommends that Resolution 2S/66 be adopted.

RESOLUTION 3S/66

Submitted on:	May 26, 1966
Introduced by:	George Vash, MD
Subject:	The Medical and Chirurgical Faculty Request the State Health Department to Rescind Its Action in Excluding the Practicing Physician's "Screening Activity" From Use of State Laboratory Facilities

Whereas, Current medical and lay opinion deems it the responsibility of every physician to practice preventive medicine and screen for the earliest signs of curable disease; and

Whereas, The scope of the Maryland Public Health Laboratory, as defined in Section 35, Article 43, Annotated Code of Maryland, 1965 Supplement, is, ". . . to provide laboratory services in screening or surveillance"; and

Whereas, The Commissioner of Health has seen fit on April 18, 1966, to define screening programs as "planned studies, within identifiable population groups toward the detection in early stages of diseases in presumably well people," and to rule, "that test specimens taken by practitioners are not at the present time to be part of the departmental screening program;" therefore be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland considers arbitrary and unlawful the Commissioner of Health's exclusion of the practicing physician's screening activity from the benefits of the Maryland State Department of Health Laboratory Services, and that the Faculty use its offices to persuade the Commissioner of Health to rescind this part of his directive.

The action taken by the State Health Department in its April 18, 1966, communication was unanimously approved by the Faculty's Liaison Committee inasmuch as it was in line with the Faculty House of Delegates policy adopted on September 12, 1958, as follows:

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty recommends to the State Board of Health and the State Health Department that they curtail the activities of the laboratory facilities in fields other than infectious, contagious disease and, specifically, they restrict all other services to patients declared indigent and medically indigent under the Medical Care program of this State, wherever private facilities are available; and

Resolved, That physicians in Maryland be urged to evaluate all referrals to State Health Department Laboratories to insure those able to pay are referred to private laboratory facilities where available.

The Maryland Society of Pathologists has already offered free services to those borderline patients who do not fall within the category of indigent or medically indigent and who are unable to pay for diagnostic tests. All the physician needs to do is to so indicate on the referral slip sent to the laboratory with the specimens or the patient.

Because the current Health Department policy falls into line with previous Faculty policy decisions reached by this House of Delegates and reiterated over the years, the Reference Committee recommends that Resolution 3S/66 be not adopted.

RESOLUTION 4S/66

Submitted on:	June 15, 1966
Introduced by:	Baltimore County Medical Association
Subject:	Development of a Program by Maryland Medical Service (Blue Shield) to Pay Reasonable and Customary Fees to Physicians

Whereas, There is an increasing demand on the part of the health insurance-buying public for the full coverage of fees for professional services; and

Whereas, The implementation of the Medicare Program will undoubtedly further increase the demand for such coverage; and

Whereas, Fee schedules for paid-in-full programs tend to become obsolete as the economy rises; and

Whereas, Most physicians in private practice feel strongly that the most appropriate way to provide such coverage, on an insured basis, is through the medium of programs that make payments for professional services on the basis of reasonable and customary fees for covered services; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urge the Maryland Blue Shield Plan to develop without delay a program whereby professional fees will be covered on the basis of reasonable and customary charges; and that such program, when developed, be sold as widely as possible to the end that it may supersede existing scheduled fee program to the greatest extent practicable.

This resolution urges Blue Shield to develop a program



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Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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whereby it would pay the physician his "reasonable and customary" charges, providing full coverage to the patient, and that Blue Shield sell this program as widely as possible.

Essentially, this is in line with the various actions that have been taken by the Faculty in recent months. Discussions are now taking place to ensure payment of "usual and customary" fees by the State Health Department in the operation of its medical care programs; with the Workmen's Compensation Commission; with other state agencies; and, of course, this is the basis for payment of physicians' fees under the Medicare program that went into effect July 1, 1966.

At the Reference Committee meeting, Mr. Denwood Kelly, the executive director of Blue Shield, stated that on instructions from the Blue Shield Board of Trustees a study is already underway to ascertain the feasibility of such a program. Nevertheless, the representative of the Baltimore County Medical Association and the Reference Committee itself believe that the Faculty should go on record to this effect.

Your Reference Committee, therefore, recommends that Resolution 4S/66 be adopted.

RESOLUTION 5S/66

Submitted on:	June 15, 1966
Introduced by:	Baltimore County Medical Association
Subject:	Payment of Reasonable and Customary Fees for Professional Services under Title XIX of PL 89-97

Whereas, The passage of Public Law 89-97, commonly known as the Medicare Act, amends the Social Security Act by creating, under Title XVIII, a program of health insurance for the aged and, under Title XIX, a program of grants to states for medical assistance programs; and

Whereas, Under both programs it is the clear intent of the Congress that payment for care provided thereunder shall he on the basis of reasonable cost or charges; and

Whereas, Under Title XIX of Public Law 89-97, the state and federal governments are jointly responsible for paying the reasonable cost of the provision of medical care for disadvantaged persons; and

Whereas, Government's assumption of the cost of such care removes the beneficiaries under such programs from the medically indigent category; and

Whereas, It is not the intent of Public Law 89-97 to interfere in any way with the close personal relationships between beneficiaries and their physicians, nor to adversely affect the quality of medical care because of inadequate financing of the cost of such care; and

Whereas, It has been clearly demonstrated in the Military Dependents Medical Care Program that average payments for professional services have been consistently lower in those areas in which such payments have been made on the basis of reasonable and customary charges, without published fee schedules, than in those in which published fee schedules were used; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland, representing the practicing physicians in Maryland, develop with the Maryland State Department of Health, at the earliest possible date, a program of health care for the disadvantaged, under the provisions of Title XIX of Public Law 89-97, under which all payments for professional services shall be on the basis of reasonable and customary charges; and be it further

Resolved, That copies of this resolution be sent to the Governor of the State of Maryland, the Budget Bureau of the State of Maryland, the Maryland State Board of Health and Mental Hygiene, and the Commissioner of Health of the State of Maryland.

This urges development of a program whereby "usual and customary" fees would be paid for services to be provided under Title XIX of PL 89-97 (the so-called Medicare law). Title XIX provides for payment of fees for care rendered under the indigent and medically indigent program that has been in operation in Maryland for many years.

In September, 1965, the Faculty's House of Delegates approved payment of "usual and customary" fees to private practicing physicians rendering care to . . . medical care program patients. In April, 1966, the Faculty's House of Delegates reaffirmed this concept and authorized appointment of a committee to deal with (a) all problems relating to PL 89-97 as it pertains to physicians' services; and (b) to deal with the fiscal intermediary for physicians' fees as they pertain to Title 18 or 19 of this law.

It would seem that this resolution is a reiteration of current Faculty policy, with the additional proviso that various officials in the state government be informed of this policy. The Reference Committee heard and agrees that this is one of the most important pieces of legislation that has come before us in a long time and it is important that we take a stand for the future, and it is therefore imperative to act now.

Your Reference Committee, therefore, recommends that Resolution 5S/66 be adopted.

RESOLUTION 6S/66

Submitted on:	July 12, 1966
Introduced by:	William G. Speed, III, MD, chairman, Fee Schedule Committee
Subject:	Billing on Workmen's Compensation Cases at Physician's "Usual, Customary and Reasonable Fees"

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37 (c), reads as follows:

> "All fees and other charges for such treatment and services shall be be subject to regulation by the Commission, and shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.";

and

Whereas, The trend today is toward payment of the physician's usual, customary and reasonable fees; and

Whereas, Hospitals throughout the state are permitted to bill carriers or others on the basis of their posted charges, without obtaining permission for any increases in such charges; now, therefore, be it

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for treatment of Workmen's Compensation Cases, as well as all other governmental agencies.

This resolution, introduced by the Chairman of the Fee Schedule Committee, was prepared after an informal discussion with the representatives of the "Continuing Committee to Study Medical and Surgical Fees Applicable to Workmen's Compensation," a committee named by the Workmen's Compensation Commissioner.

This is in line with the approval of the Council at its June, 1966, meeting when it authorized the Fee Schedule Committee to discuss with the appropriate persons the payment of usual and customary fees under

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the Workmen's Compensation Law. This is also in line with current Faculty policy providing for payment of usual and customary fees rather than having fixed fee schedules.

The resolution appears to be one mechanism for publicizing this information to the Faculty membership. It does not appear to be in violation of any antitrust regulations, inasmuch as it does not establish fees per se, but only urges members to bill at the "usual and customary" rates.

Your Reference Committee, therefore, recommends that Resolution 6S/66 be adopted.

The Reference Committee wishes to thank those who took the time to appear before it, as well as the committee members and the office staff for their research and assistance in preparing this report. Your committee also again urges individual members, as well as members of the House of Delegates, to take advantage of the opportunity of appearing at the meeting and expressing themselves on the subjects under discussion.

Respectfully submitted
EVERETT S. DIGGS, MD, *Chairman*
DEWITT E. DELAWTER, MD
HOWARD F. KINNAMON, MD
HERBERT H. LEIGHTON, MD
LAWRENCE R. WHARTON, JR., MD

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"'Tranquilizer' is not a good word"[1]

THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

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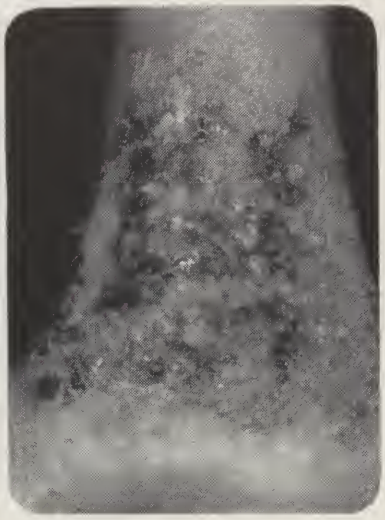
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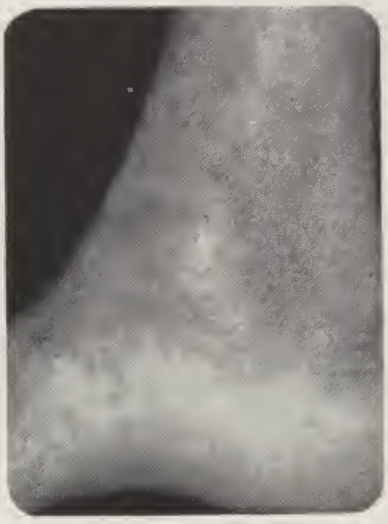
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Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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Chapter 11. Four Revolutions in Medical Care.

"Man individually and collectively will become increasingly dependent upon medicine as knowledge advances, regardless of how medical services are to be organized, practiced, or financed."[1]

This history of the Baltimore City Hospitals is concerned principally with the evolution of the Almshouse into a modern hospital, the social demands and scientific advances which brought about this transfiguration, and the changing attitudes of the community toward Welfare patients. If a revolution differs from evolution by being apparent to contemporary society, it is possible to identify four revolutions influencing medical care in Baltimore since the founding of the Baltimore City and County Almhsouse in 1773. The following revolutions were common to all the larger American cities:

1. *Improvements in Licensure and Medical Education*

Starting in the 1790's, a group of leading practitioners in Baltimore became concerned with the low level of medical care in the city. They were concerned not only with quacks and charlatans who were in practice, but also with education of young doctors. Attempts to establish a state licensure board resulted in legislative action and the founding of the Medical and Chirurgical Faculty in 1799. A number of the physicians interested in improving licensure procedures had participated in the founding of a private medical school in the 1790's under the leadership of Andrew Wiesenthal (1762-1798). The efforts to establish a permanent Medical School in the 1790's were unsuccessful, but opened the way to the founding of the College of Medicine of Maryland in 1807.[2]

This movement toward improvement in the quality of practicing physicians, although essentially a reform movement based on economic considerations, was nevertheless an essential step in the progress of medicine from a trade to an intellectual discipline.

2. *Introduction of the Scientific Method and a Humane Attitude*

In the 1830's and 1840's, the combination of improved physical examination (based on Laennec's work) and history taking, increased correlation of clinical and postmortem findings and the beginning of statistical analysis brought about a revolution in the understanding of disease. This revolution was introduced to Baltimore by Dr. William Power in the years following 1840. A graduate of the University of Maryland School of Medicine in 1835, he had been a student at the Almshouse in 1834. He followed this experience with five years of work in Paris with Pierre Louis. As resident physician at Calverton (the Baltimore City Almshouse in 1840), he introduced careful medical history taking, new methods of percussion and auscultation, proper progress notes, and clinical pathological correlations. This scientific approach to medicine, still the basis of good medical care, flourished at the Almshouse and brought to the inmates the best medical care available in the United States. This major advance was introduced by a single physician who brought to America the foremost scientific ideas

TABLE 1

A TENTATIVE ARRANGEMENT OF SOCIAL AND MEDICAL ERAS SINCE THE OPENING OF THE ALMSHOUSE

	1773-1890	1841-1890	1891-1934	1935-1966	Future Medicine
Economic challenge to Baltimore	Exhaustion by wars of 1776 and 1812; decline in plantation economy	Development of Erie Canal route to west; competition to port of Baltimore	Movement of centers of finance and industry from Baltimore	Economic depression St. Lawrence Seaway	
Response to economic challenge	Development of seaport; land speculation; industry	Development of Baltimore and Ohio Railroad	None	Government financing of health, education and welfare Greater Baltimore development plan	
Political-philosophical atmosphere	Elizabethan	Laissez-faire	Social darwinism	Welfare state	Medicare
Scientific atmosphere	Natural science	Natural science, physical, biological Clinical-Pathological	Natural physical, biological, behavioral	+ Social	+ Preventive medicine + Rehabilitation
Medical teaching 1. Teacher 2. Students	Private practitioners. Private medical school professors Apprentice students	Professors from U. of Md. School of Medicine and College of Physicians & Surgeons Selected full-time clinical clerks	+ Full-time physicians Part-time students from medical schools	Rotating clinical clerks from schools of medicine	Same + Fellows
Public health influence	Major depository of all social problems Development of smallpox vaccination	Care of orphans, insane, infirm.	Development of tuberculosis sanitarium	Baltimore City Infectious Disease Hospital (after closure of Sydenham Hospital)	Hospital-based care programs for chronic diseases
Patient care	Symptomatic treatment	Treatment of disease	Treatment of patient and disease	Treatment of disease; patient and community	+ Primary and secondary prevention
Research	Historical	Clinical-pathological correlations	Beginning of laboratory medicine	1. Clinical 2. Animal laboratory 3. Gerontology unit 4. Social	Gerontology, chronic disease, patient care research
Concept of disease	Polymorphic	Single agent	Agent⟷Host	Agent⟷Host ↕ ↕ Environment	

then being developed in Paris.

Anesthesia, aseptic surgery and new drugs to combat infections, avitaminosis and endocrinopathies are all important scientific discoveries, but had no special development at Baltimore City Hospitals.

Another important advance in medical care during this period was the changing attitude toward patients. Although these attitudes arose in relation to psychiatric patients ("moral treatment"), there is evidence that they were in use at the Baltimore City Almshouse following the year 1829. This theory of psychiatric etiology was based on the belief that insanity was a result of situational, social and genetic factors rather than possession by demons. This humanitarian attitude toward the insane in Baltimore was centered at the Maryland Hospital, located on the present site of the Johns Hopkins Hospital, and apparently was diffused to the Baltimore Almshouse from the physicians in charge. This attitude toward the insane was also an import from France where Phillip Pinel (1755-1826) had crusaded for better treatment for the insane. This is the earliest example of the influence of psychiatric thought on the general care of patients. Later, the influence of Sigmund Freud and Adolph Meyer was to insist that the insane were victims of adverse personal, social and genetic factors rather than sinners persecuted by an unjust God.

3. *Medicine, an Academic Profession*

A third revolution was the removal of the laboratories from the wards into the university research unit where body fluids and tissues could be studied and analyzed. Although this separation of the physician and the laboratory man has brought on some of the difficulties of specialization (and interest in the laboratory results rather than in the patient), it nevertheless brought the diagnosis of disease into a scientific and intellectual setting, with a result of untold improvement in medical treatment. At the Bay View Asylum, this influence was stimulated by the founding and interest of the Johns Hopkins Medical School.[3] The research laboratory itself had originated and flourished in the German medical atmosphere of the late 19th century.

In the same way that the clinical laboratory was incorporated into the academy, so the training of the physician was removed from the proprietary school into the university medical school. Physicians were not to be practitioners only; they must also be scholars learning how to approach new and unexpected problems, rather than mastering the booklearning and lectures appropriate to the past.[4]

4. *The Revolution of Rising Expectations*

The present revolution is both social and scientific. It is a revolution in the demand for the fruits of recent medical research. It is to be paid for by the federal government. It differs from the three previously discussed revolutions (which were largely narrow reform movements within the medical community to meet obviously acute existing problems) in that its impetus comes from political sources and looks toward the future. It has some of the features of previous revolutions in that it takes on a specific pragmatic American form, but originated in Europe (Germany, Scandinavian countries and Great Britain). Whether manifest in Medicare, in the Heart Disease, Cancer and Stroke Program, or in the many slogans of charitable health organizations, public opinion is informed by a belief that medical care can actually perform miracles in maintaining or improving health, and that it is not doing so. There is the assumption that all that is needed to accomplish these miracles is sufficient money.

These assumptions are, at best, debatable; that there is a revolution of rising expectations in regard to medical care can hardly be denied.

What is the Source of These Expectations?

A. In a previous chapter we have quoted L. J. Henderson's estimation that it was not until around 1912 that a random patient with a random disease consulting a randomly selected physician stood better than a 50-50 chance of benefiting from the encounter. But even these odds were based on solid and often brilliant achievement. Public health measures had shown that it was possible to eliminate or control many diseases dependent on vectors or water pollution. Vaccines, serums, antitoxins and a few chemotherapeutic agents had been proved to be potent. Surgery could be performed safely and painlessly.

But these advances did not affect the average person in his everyday life. Preventive measures do not solve individual problems. Medicine, however brilliant its accomplishments, still was in-

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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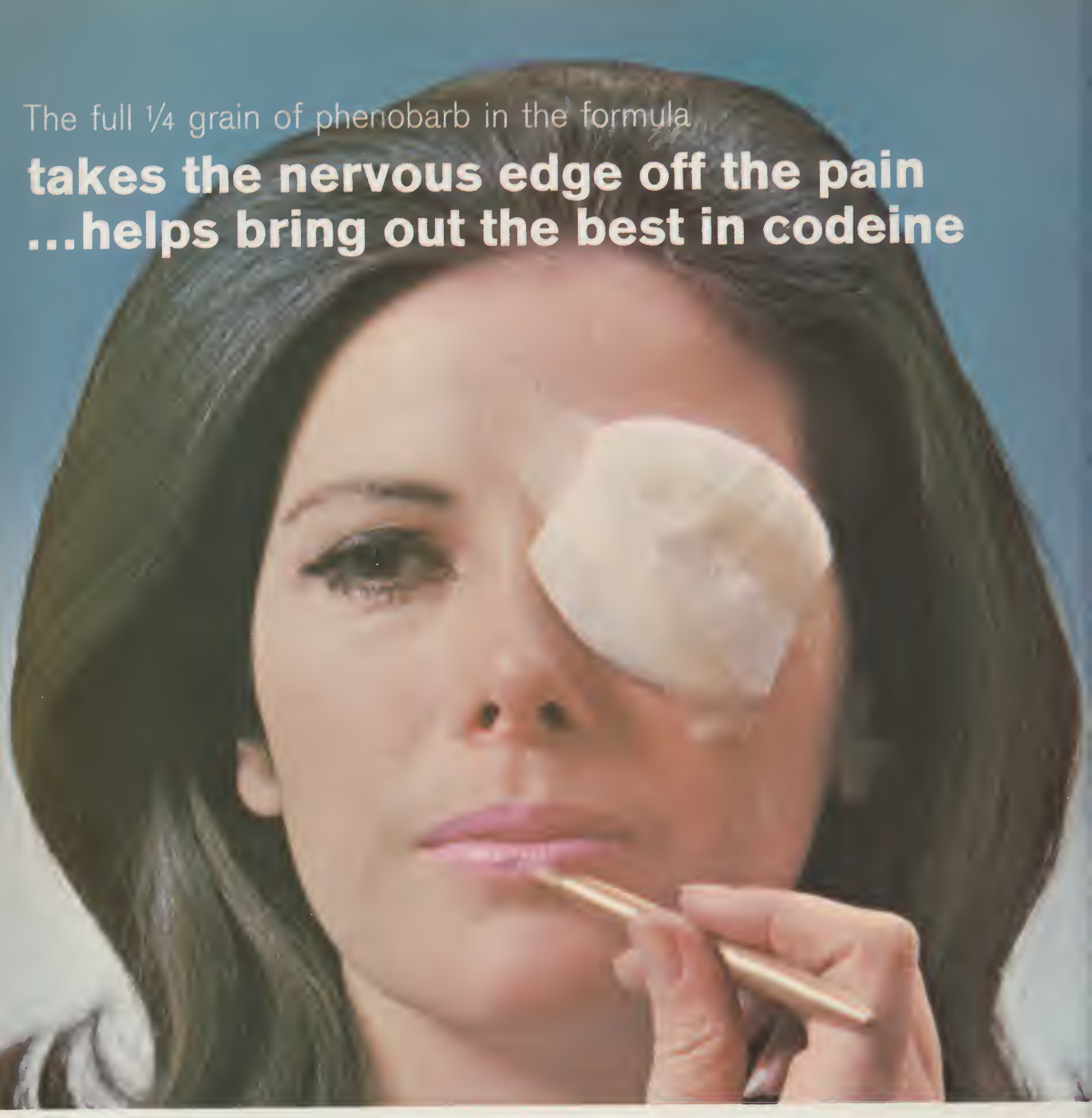
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formed by the age-old caution *primum non nocere*—do not get in the way of nature.

Dr. William Welch (1850-1934), under the influence of Julius Cohnheim (1839-1884), was one of the first to articulate[5,6] the new philosophy that nature alone does not always cure, and that actually the reparative response to disease may be deleterious to the organism as a whole. "The agencies employed by nature may be all that can be desired; they may, however, be inadequate, even helpless, and their operation may add to existing disorder. There is ample scope for the beneficent work of the physician and surgeon."[5] This new attitude opened the way to an activist approach to treatment.

Following the 1920's with the discovery of a treatment for pernicious anemia, of vitamins, insulin and, above all, the antibiotics, there has been a crescendo in the ability to cure infections, replace absent hormones, and supply needed vitamins. Nor has the surgeon been completely satisfied with the treatment of diseases. Plastic, orthopedic and cardiac surgeons have advanced into the fields of repair, reconstruction and prevention.

Most of these advances in activist medicine have been centered in the hospital. Furthermore, they affect a large number of people in their daily lives, with increasing emphasis on return to work. The hospital has indeed become an important community resource.

B. But the hospital solves other problems than those of strictly medical concern. Increasingly the domiciliary and financial problems of the chronically ill will be thrown on the hospitals. Even for

TABLE 2
HOW THE STATE OF MARYLAND GRADUALLY TOOK OVER RESPONSIBILITY FOR COMMUNITY NEEDS ORIGINALLY MET BY ALMSHOUSE

Date	Community need met by Almshouse	Year in which State took some responsibility	Year in which State took major responsibility	Where
1773	Housing of pauper infirm Housing of pauper sick		1964*	Nursing Homes
	Housing of pauper insane	1828, 1901, 1910	1943	State Mental Hospitals
	Housing of foundlings Housing of orphans			Foster Homes
	Care of acutely ill		1964*	
	Housing of vagrants		1933	City Jail
	Housing of prisoners awaiting trial Prisoners serving sentences		1811	State Penitentiary
1818	Source of medical teaching material			
1890	Housing of tuberculosis patients	1908 Sabillasville (Victor Cullen) 1913 Pine Bluff 1923 Henryton 1926 Mt. Wilson	1964*	State Tuberculosis Hospitals
1942	Center for study of aging (National Institute of Health)			
1960	Infectious disease hospital for Baltimore		1964*	
1962	Center for care of chronically ill		1964*	State Chronic Disease Hospitals

*In 1964, the State of Maryland through the Kerr-Mills Act began to pay 80% of hospital costs for care of patients. Medicare started July 1, 1966.

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the patient who cannot be cured or radically improved, the hospital is expected to rehabilitate, comfort, house and give continuous medical care. "Social" admissions to hospitals are increasing. Families having an older generation in the household are increasingly depending on hospitals to admit and take responsibility when there is a space, social or nursing problem. As hospitalization becomes a right, paid for and directed by the federal government, there will be increasing pressure to hospitalize patients for social and nursing needs. These demands will perhaps fall most heavily on municipal and state hospitals which are already set up to care for the social problems of the elderly and chronically sick.

The two Tables in this discussion attempt to summarize some of the factors influencing medical care at the Baltimore City Hospitals. They have been compiled with much oversimplificaton. Table 1 attempts to place medical care at the Baltimore City Hospitals among the wider financial, cultural, philosophical and medical trends of the times.

Table 2 is an equally oversimplified attempt to show how the multipurpose Almshouse developed into a hospital as the State of Maryland took over many of the non-hospital functions. Not mentioned in Table 2 is the fact that in 1962 most of the pauper infirm (ambulatory) were transferred to nursing homes to make room in the former Infirmary for patients with chronic diseases. The Baltimore City Welfare Department now has the responsibility of housing foundlings and orphans (foster children), although the Baltimore City Hospitals still has the responsibility of giving them medical care.

Initially the State of Maryland took the responsibility for inmates of the Almshouse by moving various groups out to different institutions. With the Kerr-Mills Act and Medicare, the State of Maryland assigns funds for care of patients within the Baltimore City Hospitals.

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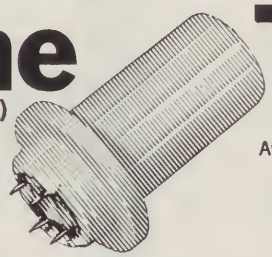
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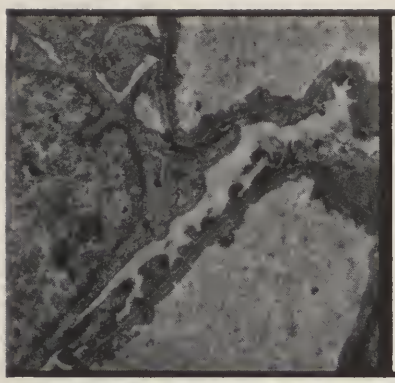
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Pathologists, Hospitals and Society: A Pathologist's Plea for Necessary Autonomy

JOHN E. ADAMS, MD
Chief of Pathology
Greater Baltimore Medical Center

In recent months pathologists seem to have been the object of growing dissatisfaction among the lay public as well as the medical profession generally, dissatisfaction originating from uncertainty as to our interests and motives. The advent of Medicare, its accompanying regulations concerning laboratory service, and our desire to protect and preserve pathology as a specialty practice of medicine have made it necessary to state our position, needs and desires repeatedly. Not a little notoriety has occurred with the lodging this year of an antitrust suit against pathologists and our professional societies. It seems appropriate, therefore, to attempt to explain our position and to correct some of the misconceptions arising from these events, for it is apparent that many of our problems, motives and goals have not been made clear to the rest of the profession. Perhaps if a measure of insight into some of these problems is attained, the rest of the profession will support pathology and pathologists more vigorously in this difficult period. This support will be most opportune, since there is ample evidence at this time to suggest that the fate of pathology will presage the future of medical practice in this country.

Most pathologists who have responsibility for a broad based, non-private laboratory service are interested in at least some degree of autonomy. The desire for autonomy at times has been equated with a desire for increasing personal gain. It cannot be guaranteed that this motive is non-existent, but there are many more important reasons why a degree of autonomy is essential to the satisfactory practice of pathology. Pathologists are subject to many opposing pressures from other physicians and hospital administrations. While hospital administrations demand economical practice and require evidence of rapid amortization, clinicians require a broad base of accurate and rapid service, together with an ever increasing scope of operation. It is difficult in the average hospital to increase scope to include more expensive and less popular tests because the necessary equipment and personnel are difficult to justify economically. In this period of rapidly rising hospitalization costs, administrations are necessarily preoccupied with per diem costs and a balanced operating budget. Understandably, they are not easily enamored of the idea of supporting activities in a semi-research or fiscally unsound category.

Satisfactory laboratory service begins with the collection of a specimen and ends with a legible report on the patient's chart in a short period of time. Between these limits are myriads of intermediate and ancillary services upon which the pathologist must depend and over which, in most

cases, he has a highly variable, and far less than complete, control. With respect to sources of problems, the actual performance of the tests assumes secondary importance. If there is a breakdown in any of the steps between specimen collection and test reporting, the pathologist's effectiveness is jeopardized, notwithstanding that many of the intermediate steps may be beyond the pathologist's control. When a test cannot be completed because a line of supply is disrupted, personnel are unavailable or a piece of equipment is not on hand, the pathologist must assume responsibility for a defect in laboratory management. He therefore must be concerned with as much autonomy as he can attain, since he must otherwise assume total responsibility without total control.

One prime motivation for seeking a career in medicine is independence, with the ability to direct one's own course under minimal outside influence. Most physicians jealously guard this degree of independence and sacrifice considerably in other areas in order to attain and preserve it. Pathologists are no different from other physicians in this regard. A considerable sacrifice of independence is involved in the practice of pathology, which pathologists must be willing to accept as inherent in the practice. Yet at the same time, we should not be unduly criticized for attempting to seek as much independence as possible. I expect that if a satisfactory degree of autonomy were allowed the average pathologist, he would be delighted to have his financial arrangements and records examined by anyone who might care to look.

Other current criticisms are that pathologists have attempted to keep laboratory costs at an artificially high level and that they have tended to stifle competition from nonpathologist-directed laboratories by tacit internal trust agreements. It is true that pathologists believe laboratories dealing in the diagnosis of human disease should be directed by a physician who has special training in such supervision and that other direction may carry risks which are unnecessary and unwise. This is no different from the belief of most physicians that each specialty is best practiced by physicians trained in that specialty. It is as difficult to consider this belief in pathology as a trust as it is to consider every specialty practice as a trust. The concept has been misconstrued because of the business aspect of the practice of pathology.

Through the years, it has been the custom of hospitals to assign unrealistically low values to the cost of various phases of hospital care such as the patient room, nursing, and other ancillary services, while depending upon pathology and radiology laboratories to provide a margin of profit sufficient to balance the books. Reimbursement by major hospitalization insurance plans is largely geared to this concept. Hospitals cannot agree to the lowering of laboratory charges to more appropriate levels without raising the costs of other hospital services. Insurers are not yet ready to accept the concept of strict cost accounting of all hospital services and hospitals are powerless to correct the situation until the insurers can cooperate. Until insurers are able to readjust their reimbursement methods to allow hospitals to assign true cost figures to the cost of the various patient care services, pathologists will be powerless to reduce the cost of laboratory tests. Pathologists for years have been anxious to escape from the yoke of supporting other hospital services, but until cost accounting procedures are instituted and insurance reimbursement is adapted to this concept, laboratory charges will not come down.

One accurate definition of a satisfactory practice of pathology is laboratory service provided with all possible speed, accuracy and at the lowest possible cost to the patient. Pathologists accept this definition as their major aim; however, without a degree of autonomy sufficient to control most operations upon which the laboratories are dependent, and freedom to set laboratory charges at their true value without a built-in profit margin to carry other hospital services, pathologists will be unable to achieve this goal.

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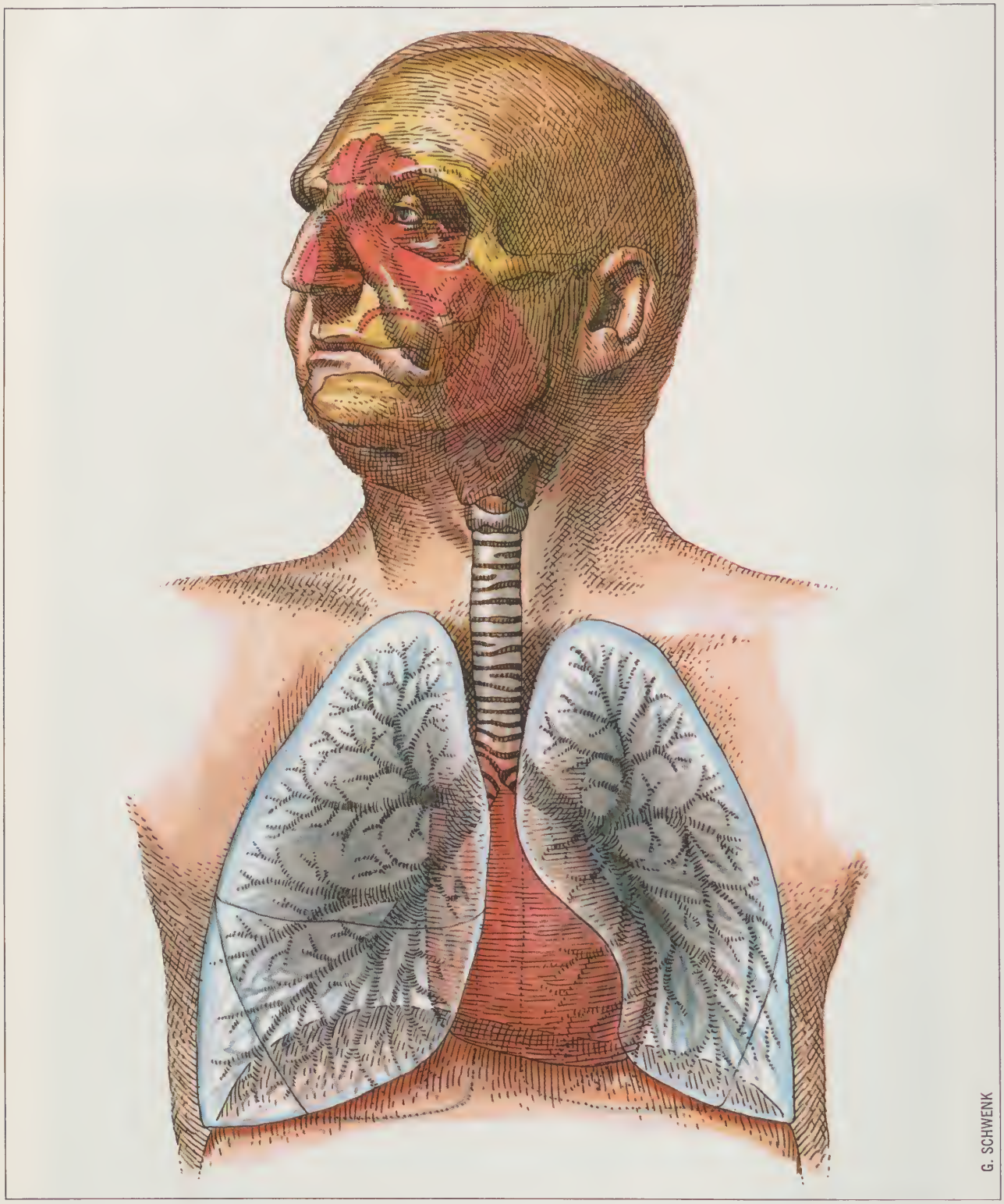
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this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



G. SCHWENK

Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to bronchopneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

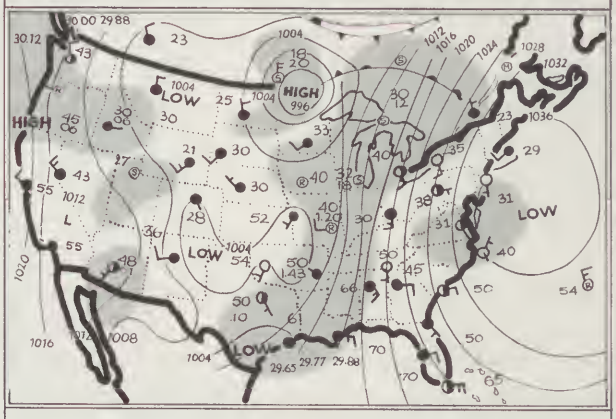
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

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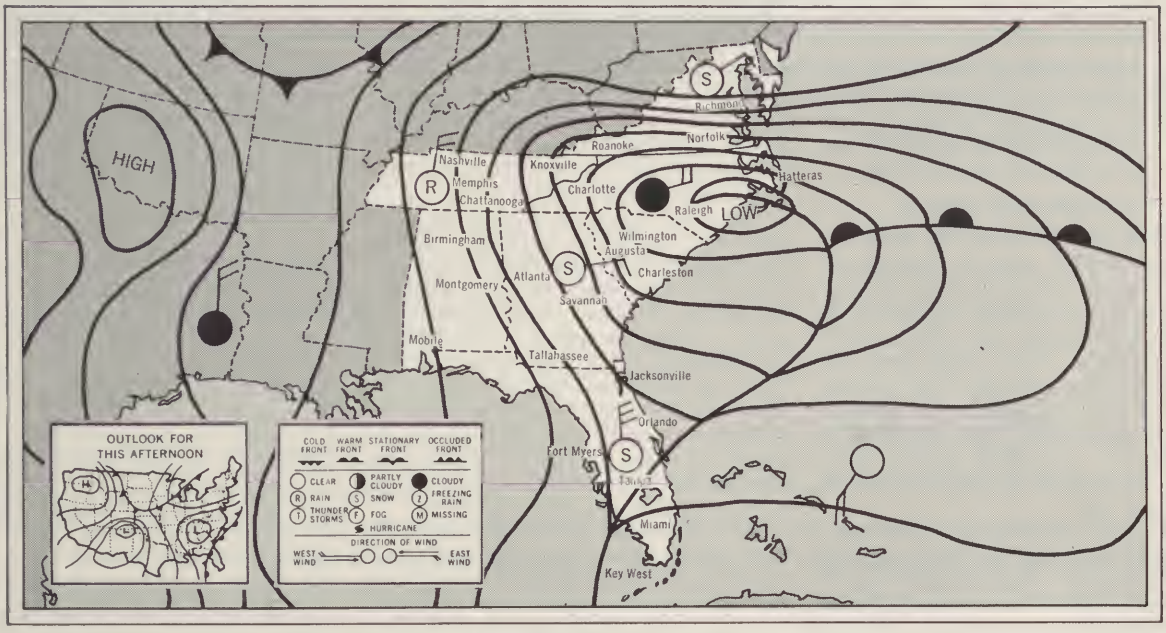
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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

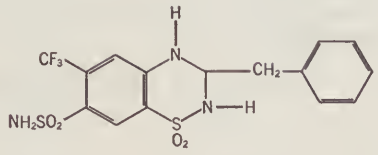
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

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Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

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GROWTH FAILURE

MILTON S. GROSSMAN, MD
Assistant Professor of Pediatrics
University of Maryland School of Medicine

The etiology of growth failure is one of the more perplexing problems engendered by the physician who cares for the pediatric and/or adolescent population. In dealing with the adolescent patient, it is imperative to distinguish between delayed adolescence and all other causes of short stature. The patient with delayed adolescence may be a "late bloomer" whose final height will eventually be quite adequate. In this regard a bone age x-ray (as described below) can be most useful. Gruelich and Pyle's Atlas (Stanford University Press, 1959) has prediction tables that enable one to predict final height from the bone age and the current height. Usually, girls menstruate at a bone age of 13. Growth continues until the bony epiphyses fuse (a bone age of 16 for girls and a bone age of 18 for boys). However, sex steroids enhance fusion, causing very rapid maturation of bone in great excess of increments of height. Therefore, it does not make sense to give estrogens or androgens to *short* late bloomers. One can only hasten epiphyseal fusion. Hypopituitary patients in their 20's have been found to be capable of further growth! In my opinion, the use of sex steroids in the treatment of delayed adolescence or short stature of any etiology should therefore be confined to use only by the endocrinologist after a careful endocrinological evaluation.

All endocrine imbalance can positively or negatively influence growth. Hypopituitarism and, sometimes, hypothyroidism are the most insidious forms of endocrine imbalance, in that their presence can easily go undetected for many years sometimes not being suspected until adolescence. More importantly, today both of these entities can be adequately treated—hypopituitarism with human growth hormone (somatotrophin) plus other replacement hormones of animal or synthetic origin, and hypothyroidism with desiccated thyroid. In contrast to all of the other endocrine hormones, only human growth hormone can make humans grow—the animal growth hormones do not work. Therefore, this material is in extremely short supply and can only be obtained through the endocrinologist who obtains it from the National Pituitary Agency in Baltimore. In contrast to the sex steroids, somatotrophin does not increase bone age at all! Ten percent of all causes of growth failure not due to undernutrition (see below) are due to lack of growth hormone. The diagnosis and treatment of hypopituitarism are beyond the scope of this presentation. The specialized techniques involve the measurement of radioimmunochemical growth hormone in millimicrogram amounts in the serum in the fasting state and, after release-provoking hypoglycemia or arginine infusion, involve measurements of thyroid, adrenal, and gonadal function, etc. Unfortunately, these procedures are currently available only through medical school endocrine groups such as those at the five medical schools in the Baltimore-

Washington, DC area.

Short stature can be a by-product of chronic disease of any organ system (ie, liver, kidney, heart, lungs, etc). In the United States the most common cause of short stature is short parents (genetic). In the world, the most common cause of short stature is undernutrition (hypocaloric dwarfism). Hypocaloric dwarfism can result from inadequate nutritional intake (starvation), inadequate intestinal absorption (malabsorption syndromes, disaccharidase deficiency, exudative enteropathies, etc), faulty transport or distribution of essential nutriments (hypoproteinemia, etc), or inadequate metabolism of nutriments by the tissues (glycogen storage disease, etc). Poor growth can result from prenatal influences (ie, intra-uterine growth retardation secondary to placental dysfunction—the "withering-on-the-vine" syndrone), or perinatal influence (ie neonatal anexia, central nervous system bleeding, subdural effusion, etc).

Other causes of poor growth are: (a) congenital bone disorders (ie, chondrodystrophies, metaphyseal dysostosis, estrogenesis imperfecta, etc); (b) multiple congenital anomaly syndrome; (c) chromosomal aberrations, including chromosomal mosaicism (gonadal dysgenesis, etc); and (d) "the garbage-can syndrome" or Powell-Blizzard dwarf. These children have an adequate nutritional intake but a severely disturbed emotional environment. They often test out a hypopituitary child but their perimeters of endocrine function return to normal when placed in a good environment!

While the definitive diagnosis of many of the above causes of growth failure may require elaborate laboratory tests available only in large teaching centers, the most valuable measurements for diagnosis are available to *all* physicians in their offices: these are the careful measurements of age (to the nearest month), height, and weight, *and* the plotting of these measurements on a standard growth curve. A child can sustain no major disease of any organ system without having it reflected in altered growth. The Table illustrates the value of careful repeated measurements and how this data can be interpreted.

In the Table, growth data are compiled on six hypothetical children, five of whom have short stature. This Table should prove to be a useful guide for screening causes of growth failure. Height age and weight age are obtained from standard growth charts, such as in Nelson's Textbook of Pediatrics. Height age is that age (to the nearest month) at which the patient's current height would be in the 50th percentile (ie, one moves horizontally on the growth chart until the 50th percentile is intersected and then reads the age by moving vertically to the age intercept). Weight age is obtained in the same manner. Bone age is obtained by x-ray examination of the skeleton, especially the wrist. The wrist x-rays are compared to standards compiled by Gruelich and Pyle. To use the Table properly, one must realize that bone age is usually read by the radiologist in relation to chronologic age. However, the endocrinologist has found that, clinically, bone age

SCHEMATIC COMPARISON OF CAUSES OF GROWTH FAILURE

	Chronologic Age, Yr	Height Age, Yr	Weight Age, Yr	Bone Age, Yr
"Average"	6 0/12	6 0/12	6 0/12	6 0/12
Genetically short Stature	6 0/12	3 0/12	3 0/12	3 to 6
Hypothyroidism	6 0/12	3 0/12	5 0/12*	0 to 6/12†
Hypopituitarism	6 0/12	3 0/12	3 0/12	2 to 4‡
Hypocaloric dwarfism	6 0/12	3 0/12	1 to 2§	3 to 6
Miscellaneous (ie, gonadal dysgenesis, chondrodystrophy, etc)	6 0/12	3 0/12	3 0/12	3 to 6

*Weight age is greater than height age.
†Bone age is much less than height age.
‡Bone age is usually spread over a two-year period with an average equal to or greater than height age.
§By definition, weight age is much less than height age.

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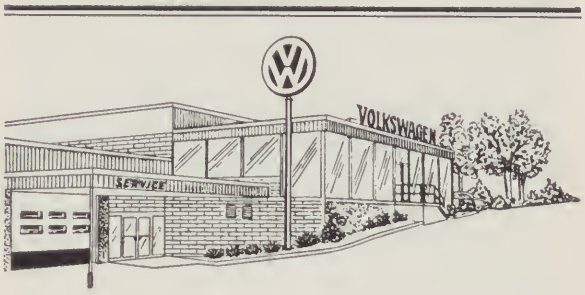
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is best compared to height age. Therefore, a "retarded" bone age is one that is *less than height age,* independent of chronologic age. An *advanced* bone age, however, is one that is greater than chronologic age, and/or height age, whichever is the greater. Weight age, likewise, makes more sense when compared to height age, not chronologic age.

You will note from the Table that the genetically short child can be quite similar to the hypopituitary child; yet, there are often striking differences. The genetically short child usually looks his *chronologic age,* not his height age, while the hypopituitary child has the proportions and immaturity of appearance of his *height age,* not his actual age. Hypopituitary children are usually two standard deviations *below* the third percentile. Almost no other cause of short stature is so profound.

Many causes of short stature can be treated today, including hypopituitarism. It therefore behooves the physician to carefully weigh, measure, and graph all growing children so that growth failure will be detected as early as possible. Only then will it be possible to be sure that each child has the opportunity to reach his maximum growth potential. In the last analysis, that is the physician's responsibility to each child in his care.

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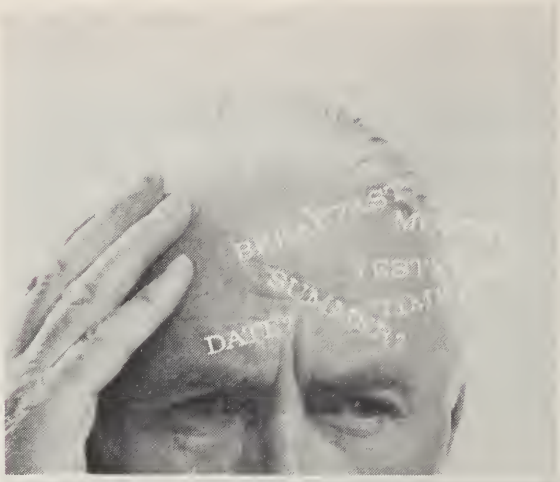
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Alcoholism SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

The Effects of Alcohol on the Brain

"The alcohol withdrawal syndrome, with its complications of tremors, convulsions, hallucinations and delirium tremens, is a direct effect of alcohol on the brain," said Stanley Gitlow, MD, at the annual symposium of the New York Medical Society on Alcoholism in a combined meeting with the National Council on Alcoholism.

Alcohol has two effects on brain function: sedation lasting 5 to 6 hours and psychomotor hyperactivity lasting 12 to 24 hours. Therefore ethanol intoxication has a clinical picture representing the sum of two asynchronous and opposing pharmacological effects.

The term "withdrawal syndrome" is thus somewhat of a misnomer since it defines a primary and direct pharmacologic result of ethanol upon the brain, and the patient may actually suffer from it long before the cessation of alcohol ingestion. The psychomotor hyperactivity becomes apparent within two to five hours after ingestion of alcohol, as the sedative action wanes.

Physicians should be suspicious of the ingestion of other soporifics or of complicating pathology if the alcoholic patient is deeply comatose after that time. In contrast to its sedative effect, Dr. Gitlow said, the psychomotor hyperactivity effect of alcohol is dose-dependent and becomes more prolonged with higher amounts. Recovery from this phase is largely accomplished within three to four days after its onset; complete disappearance of its more subtle characteristics will take weeks.

Phenothiazines are the most useful drugs in controlling the excess psychomotor activity of the withdrawal state; however, they fail to do for the alcoholic what ethanol, barbiturates, chloral hydrate, glutethimide and paraldehyde do "only too well."

In the series of over 1,000 patients treated for alcohol withdrawal syndrome with chloropromazine, Dr. Gitlow declared, not a single instance of intrahepatic cholestatic hepatitis was noted.

He warned against prescribing ethanol during withdrawal to replace other sedatives, since its sedative action is too brief, its psychomotor effect too strong, and its demoralizing effect on the alcoholic pronounced. Patient care is simplified, he said, by the abrupt cessation of ethanol, and the physician's role in reference to the patient and his problem is clarified because the objective is to help the patient attain and maintain abstinence rather than to teach him how to drink ethanol more successfully.

In support of this approach, he reported that when alternate patients were treated with abrupt withdrawal from alcohol versus gradual weaning from alcohol, the incidence of delirium tremens was the same.

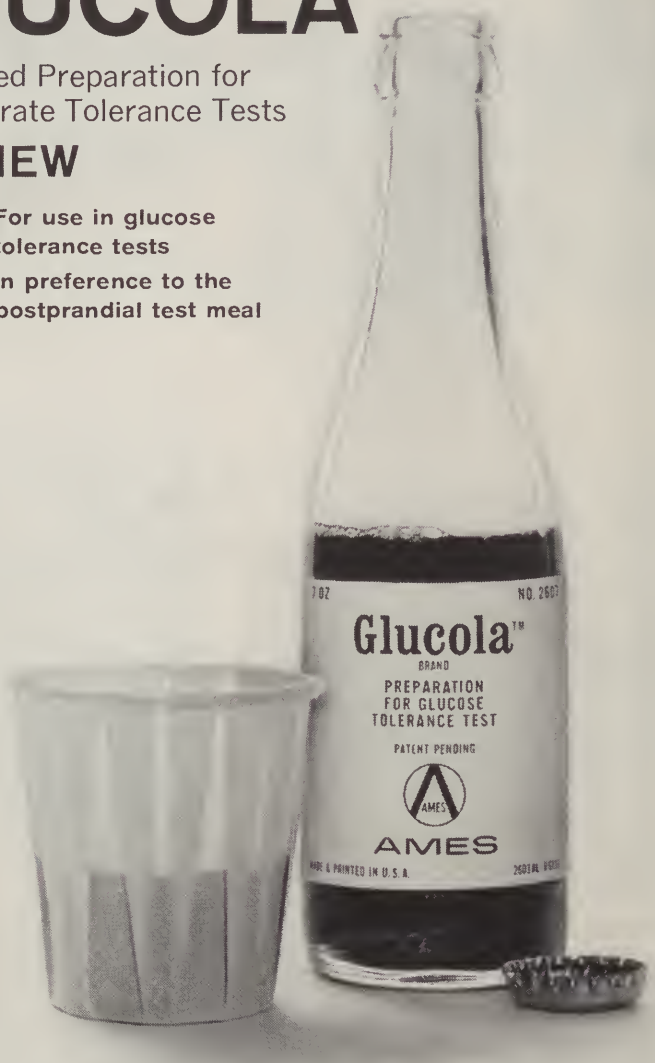
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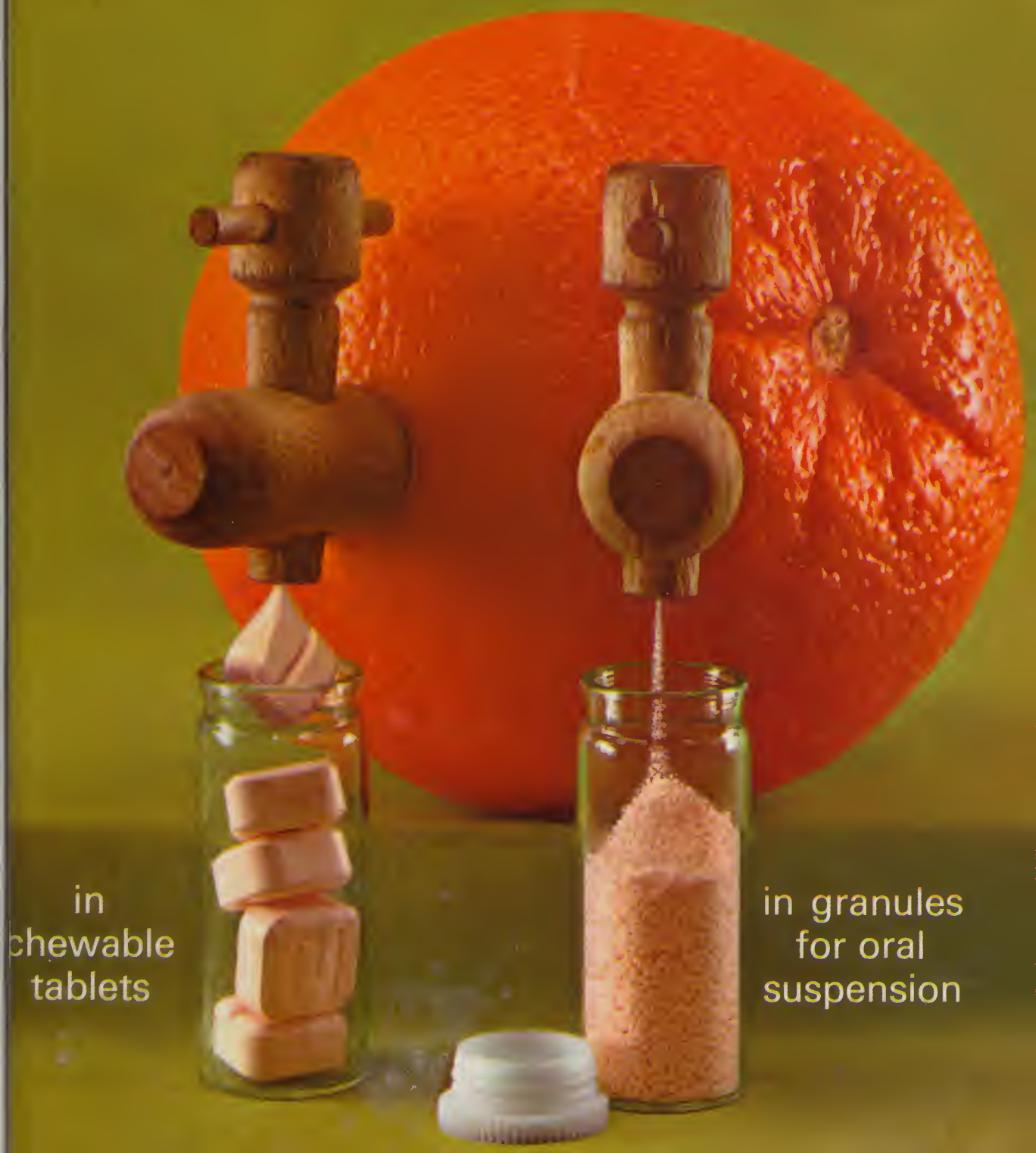
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Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

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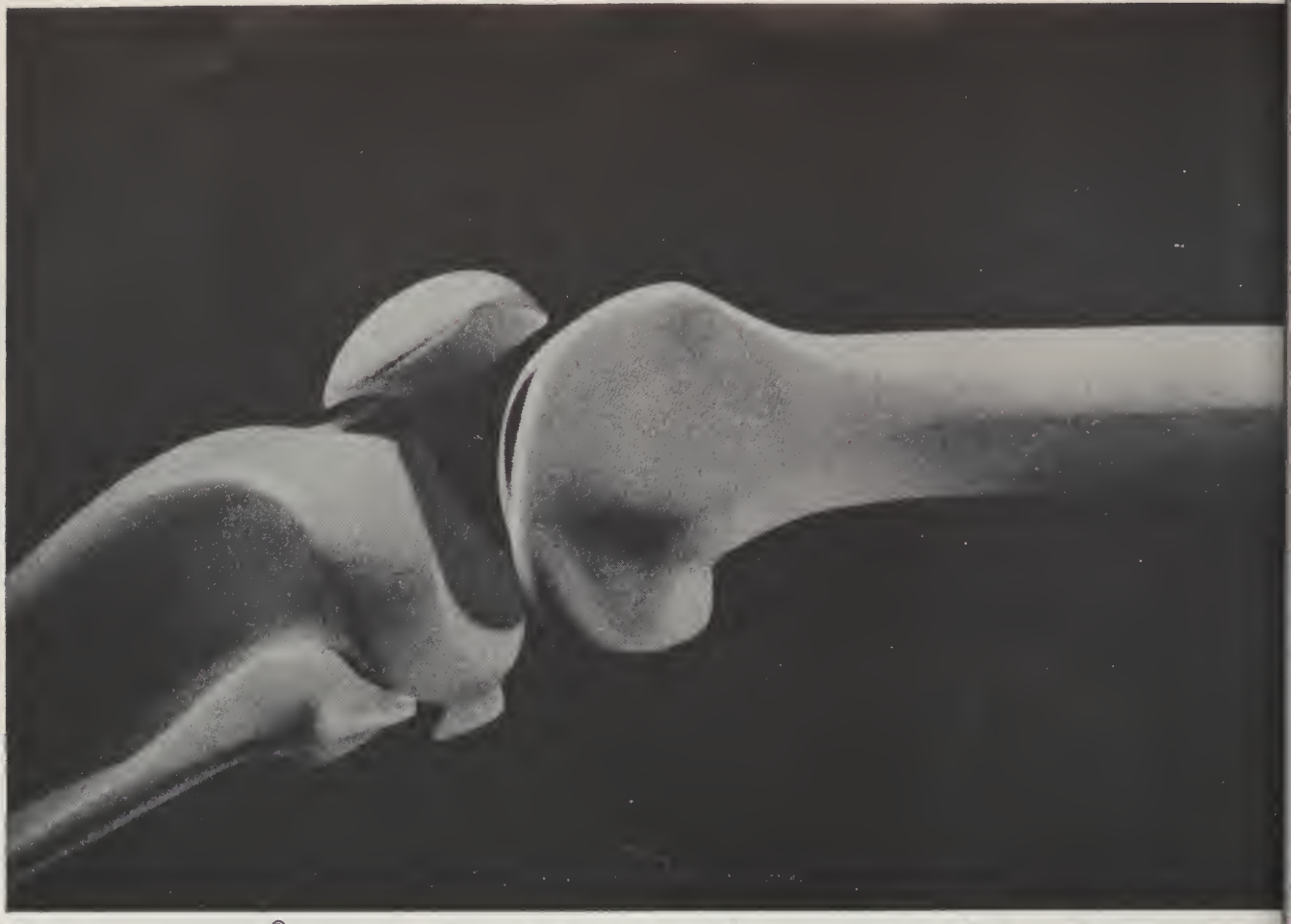
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Aberrant Conduction During Auricular Fibrillation

HAROLD H. BIX, MD
Head, Division of Cardiology
North Charles General Hospital

Aberration is the name which was given by Lewis to designate an abnormal spread of a supraventricular impulse through the conduction system. Aberration gives rise to an altered form of the QRS complex and occurs if an impulse appears in early diastole before the tissue has completely recovered from the previous beat. Aberrant beats, therefore, are very often seen in early premature supraventricular beats, in early capture beats interrupting A-V dissociation and in some other conditions, such as in the first beat initiating a supraventricular tachycardia and in beats ending the shorter ventricular cycle in 3:2 A-V block etc.

The occurrence of aberration depends on the state of relative refractoriness, which in turn is influenced by the length of the preceding cycle, ie, by the heart rate.[1, 2] The duration of the recovery period is longer after a longer preceding cycle, ie, after slowing of the rate. One therefore sees aberration particularly in beats which terminate a short cycle preceded by a longer cycle, such as in the first premature beat which signifies the onset of a paroxysmal supraventricular tachycardia.

Aberrant ventricular conduction is often confused with premature ventricular beats, particularly during auricular fibrillation. A visible P wave preceding the anomalous ventricular beat makes it easy to recognize aberrant conduction. In auricular fibrillation, however, where eliciting atrial impulses cannot be recognized, difficulty may arise in distinguishing between aberrant conduction and ectopic ventricular beats. Very often runs of such aberrant beats may be confused with ventricular tachycardia.[3] There is no doubt, that the recognition of aberrant ventricular conduction during auricular fibrillation is often of great importance and will lead to the correct treatment with Digitalis, which in the presence of frequent ventricular ectopic beats or ventricular tachycardia would be contraindicated.

It is the purpose of this presentation to enumerate and discuss some of the criteria which have been advanced for the differentiation of ectopic ventricular beats and aberrant beats during auricular fibrillation.[4, 5] In favor of aberration are: (1) Right Bundle Branch Block pattern, (2) variable couplings, (3) long-short cycle sequence (aberration usually terminates a short cycle preceded by a long one [3, 4]) and (4) lack of a long pause following the anomalous beat (a long pause favors ventricular ectopic beat). These proposed criteria are often helpful in the correct interpretation during auricular fibrillation; they are in no way foolproof, however:

(1) It is true that 80%-85% of aberrant beats

show an RBBB pattern[3] but, although this observation is certainly in favor of aberration, it has been shown that 63% of ventricular extrasystoles mimic RBBB,[6] which in turn diminishes the value of this pattern in the differentiation of the beats in question.

(2) The coupling interval is of value only if there are many anomalous beats for comparison present. Although fixed coupling may point more to ectopy, ventricular extrasystoles often show some variation in the coupling interval.

(3) Although long preceding cycles may set the stage for aberration, ventricular extrasystoles in form of bigeminy may also be precipitated by a lengthened ventricular cycle, a phenomenon which has been described as "rule of bigeminy,"[7] and which might limit the value of the long-short cycle sequence as a sign of aberration.

(4) A long pause, like a compensatory pause during sinus rhythm, often follows an ectopic beat. A ventricular beat can be interpolated without being followed by any pause, however, whereas aberrant beats are occasionally followed by a long pause.

Marriott and Sandler have recently shown[8] that, despite the available criteria and even with the help of additional criteria which they reported, no definite distinction can occasionally be made between ectopy and aberration. In looking for additional criteria, they found that 70% of aberrant beats showing an RBBB pattern in Lead VI have a triphasic (rsR′, rSR′ or rsr′) pattern compared with only 6% of ventricular extrasystoles that mimic RBBB. Conversely, 92% of ectopic beats mimicking RBBB showed a mono- or diphasic pattern (R, qR, PS or qr) in VI. In studying the initial vector of the QRS complex they also found that it is unusual (only in 4%) for the initial vector of a ventricular extrasystole to be identical with that of the flanking conducted beat, but found it common to show an identical initial vector in aberrant beats. They therefore came to the conclusion that a triphasic QRS pattern and an identical initial vector provide rather strong evidence in favor of aberration. A different initial vector, however, does not exclude it. These authors also mention a few other signs which might be helpful in differentiating between aberration and ectopy during auricular fibrillation, for example, the presence of similar bizarre beats in previous or following non-fibrillating tracing, undue prematurity, and the absence of a long preceding cycle, all of which favor ectopy.

In the Figure, tracings are illustrated in which the above mentioned criteria, particularly the recently described combined triphasic initial vector criterion, seem to be very helpful in the important differentiation between aberrant beats and ectopic beats during auricular fibrillation. All of the tracings were taken in Lead V1.

A) *A single aberrant beat during auricular fibrillation.* It shows an initial vector identical with that of the flanking conducted beats and a triphasic (rsR') contour. The aberrant beat is premature and terminates a short cycle preceded by a long one.

B) *A similar beat from the same patient that may or may not be aberrant.* It has a different initial vector and a diphasic (qR) contour. The premature abnormal beat is not followed by a pause.

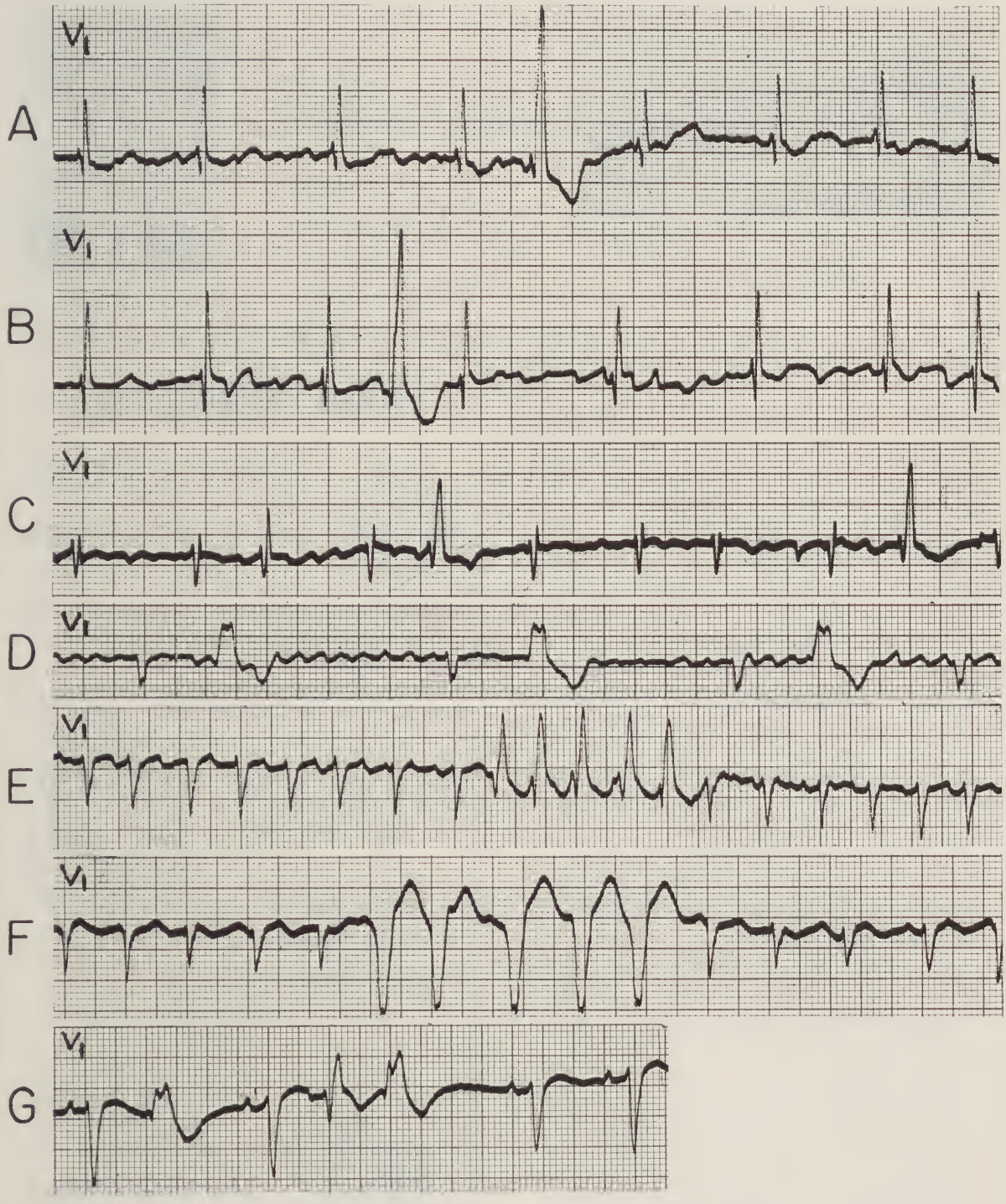
C) *Varying degrees of aberration in the 3rd, 5th and 10th beat; triphasic contour and identical initial vector.* The aberrant beats terminate a short cycle preceded by a long one.

D) *Ventricular bigeminy during auricular fibrillation.* The coupling interval is fixed. Note the RBBB pattern but with a qR pattern and different initial vector.

E) *Auricular fibrillation with rapid ventricular response.* In the middle of the tracing there is a run of undoubted aberration simulating ventricular tachycardia. Note here the triphasic (rsR') pattern and identical initial vector.

F) *Run of anomalous beats during auricular fibrillation representing an ectopic ventricular mechanism.* Note the LBBB pattern and the cycle-sequence that militates against aberration—why should the third beat of the run be aberrant since it ends a much longer cycle than many of the conducted beats that are not aberrant?

G) *The combined triphasic-initial vector criterion, well illustrated during a sinus rhythm.* An auricular premature beat and a ventricular beat are side by side: both show RBBB pattern; the auricular beat (4th beat) shows a triphasic con-



TRACINGS ILLUSTRATING CRITERIA

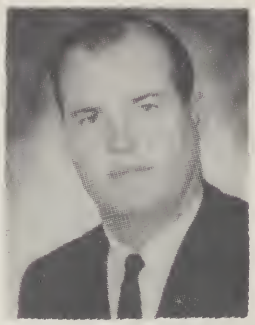
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tour and same initial vector as the sinus beat, whereas the two ventricular premature beats show a diphasic (qR) contour and different initial vector.

In many tracings the differentiation between ectopy and aberration might be of purely academic interest (A and B in the Figure). In such tracings as those illustrated in E and F, however, the exact differentiation is certainly of great importance from the point of prognosis and treatment. A rapid run of aberrant beats, as seen in E, which is not too uncommon, imitates ventricular tachycardia; not recognizing this condition might deprive the patient from receiving Digitalis which might be lifesaving. On the other hand, not recognizing the ectopic ventricular mechanism in F, particularly in the presence of Digitalis treatment, might lead to ventricular fibrillation.

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Improving Communication Between Special Education and Medicine

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Coppin State College, Baltimore

For too long a time the medical profession has set itself apart from the general public and from education. Operating from behind barriers of a highly specialized and often incomprehensible idioglossia, the doctors have fostered an aura of mystery, of privileged information. So, too, have the special educators cut themselves off from the mainstream behind a smokescreen of special jargon. Both professions play the alphabet game which may facilitate intra-professional communication but confuses inter-professional discourse. The doctor speaks of CVAs, EEGs, children with PKU, while the special educator talks about his BI, MR, and ED children.

Because there is a need for interdisciplinary communication among the professional fields involved in the education of the exceptional child, it is essential that there be effective means of communication. Professional workers must become increasingly aware of the skills involved in communicating ideas. There is a need to clarify the basic concepts, the underlying principles, and the objectives of education and of medicine. Hand in hand with this is the obvious need to clarify and standardize terminology and definitions. For example, in a retarded population, there is a wide variation of etiologies, intellectual levels, and behavior patterns. Despite the fact that mental retardation is itself a practically meaningless categorization, many doctors make educational diagnoses and prognoses on the basis of their medical findings. Too often the special educator must deal with bitter and frustrated parents of mildly and of moderately retarded youngsters, who had been told by a physician that their child would "grow out of it." There is an urgent need for the special educator to: (1) standardize terminology within his own field, (2) facilitate the understanding of this terminology among other groups, and (3) become conversant with the terminology and practices of the medical field and its ancillary disciplines.

While the standardization of terminology is not of such vital concern in the more exact science of medicine as it is in the behavorial sciences, the medical profession needs to (1) comprehend and become conversant with the terminology and practices of education, and (2) facilitate the understanding of its terminology among the other professions.

Special education has become increasingly aware of the problems of communication and has taken various steps to remedy the deficiencies. In the field of mental retardation, the American Association on Mental Deficiency has attempted to standardize nomenclature. Teacher preparation programs reflect an increasing awareness that the special teacher requires an understanding of the language of the medical profession. Guest lecturers from medicine, team teaching (doctors and special educators), courses in other academic departments, clinical and hospital experiences, and specialized courses such as "Medical Information

for the Teacher" (to be offered soon at Coppin State College) are helping the special educator communicate more effectively with the doctor. There have been few other organized efforts in the special education field, however, to facilitate the understanding of terminology and special education practices among other groups. Perhaps teacher education institutions and professional associations can assist in this process by establishing institutes and workshops in which both professions actively participate.

Moreover, there has been little organized effort by the medical profession to facilitate the understanding of its language among the other professions. Perhaps the self-image of the doctor militates against this kind of fluency. If a group sees itself as an entity apart from the general community, it will not wish to communicate and will operate from behind walls erected by secret society and fraternal in-group mentalities. It appears that the medical profession may be losing sight of the fact that the special teacher will be better able to converse with the doctor if the teacher knows, for example, that bladder and sphincter control often are absent in spina bifida and, at the same time, do a better teaching job if he is aware of the resulting psychological problems and their effects upon the teaching-learning process. The teacher, on many occasions, requires medical information in establishing an educational diagnosis and prognosis. Certainly, the presence of nystagmus will adversely affect reading and the teacher needs to know this. And, reciprocally, a teacher's description of the behavioral and learning disabilities of the minimally brain-damaged child will aid the doctor in his diagnosis of brain damage.

The need to become more familiar with the terminology and practices of special education has not been met. Special educators should be brought into medical schools as guest lecturers and special education courses should be instituted in medical schools. (This is being done at the University of Colorado Medical School.) As the special educator is being required to obtain hospital and clinical experience, perhaps, the doctor should be encouraged to devote some time to classroom observation.

This article is perhaps inappropriately titled. The task at hand may not be learning to improve communication, but rather learning how to communicate. In order to do this, the two professions must find opportunities to sit down together at professional conferences and institutes, in classrooms and workshops. They must share knowledge in team teaching endeavors, in special courses, in guest lectures, in interdisciplinary staff conferences, and in informal meetings. They must examine concepts of self-image. The teacher must stop thinking of himself as low man on the totem pole, and the doctor must stop thinking of himself as the Brahmin of the interdisciplinary team, for only when each profession views itself as an equally vital member of the team can fluent, effective, and meaningful communication occur.


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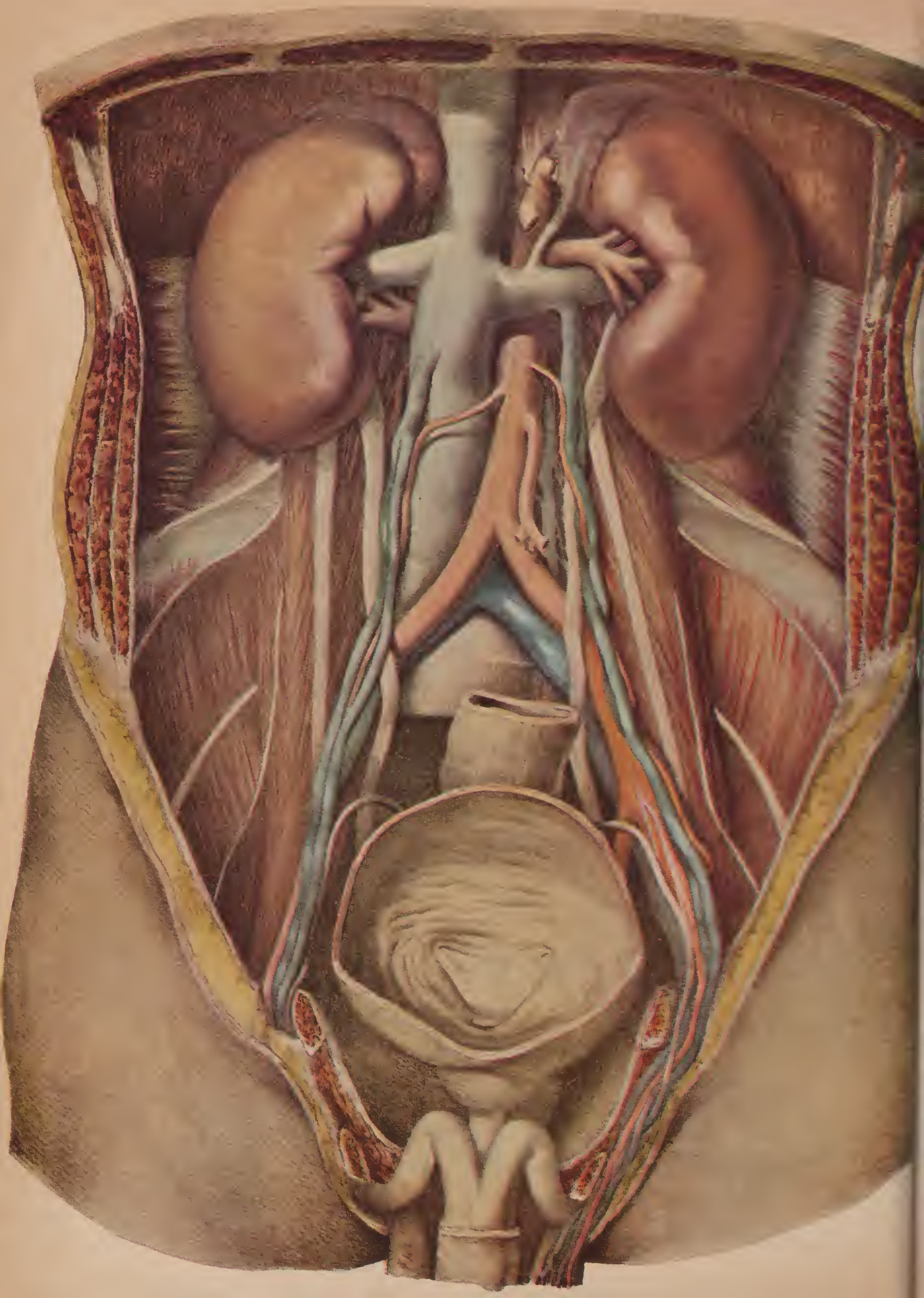
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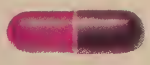
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Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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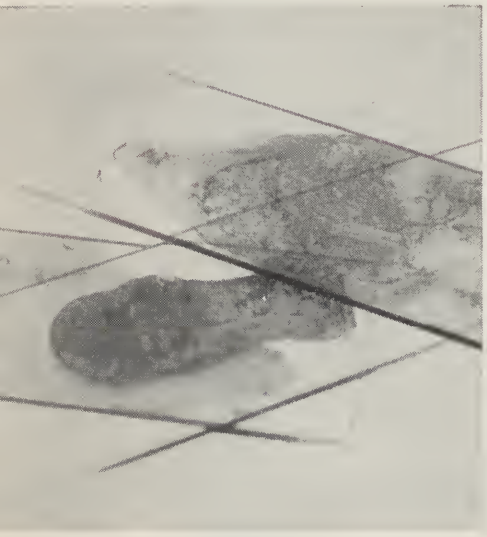
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gonorrheal therapy, serologic tests for syphilis sh
conducted initially and monthly for 3 months.
Reactions: Glossitis, stomatitis, nausea, diarrhe
lence, proctitis, vaginitis, dermatitis, and allergic r
may occur. *Usual Adult Dosage:* 1 capsule *q.i.d.*
therapy for 10 days in beta-hemolytic streptococc
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DOUGLAS G. CARROLL M.D.
EDITOR

Exercise and Coronary Artery Disease

For years physicians have been fascinated with the relationship of exercise to coronary artery disease (CAD) and acute myocardial infarction (AMI). The question arises in three settings: first, whether the habitual level of exercise required in the patient's occupation is related to the severity or mortality of CAD; second, whether acute and severe exertion brings on AMI; and third, how much exercise should be allowed following recovery from AMI, how soon the patient should be allowed up, and how fast he should be mobilized.

1. Association Between Habitual Activity Level and Coronary Artery Disease

A number of studies have been performed in various industries comparing sedentary workers, such as clerks, telegraphers, telephonists, supervisory personnel and bus drivers, with more physically active workers, such as postmen, conductors on buses and switchmen in the railroad industry. Most studies have demonstrated that the incidence of CAD is higher among sedentary workers. For example, Taylor[1] comparing death rates among clerks, switchmen and section men in the railroad industry, showed that there was a consistently increasing death rate per 1,000 at different age groups—with the lowest rate among section men, a slightly higher rate among switchmen and the highest among clerks.

Morris et al[2] reported a higher incidence of CAD in drivers in the London Transport Executive than in the conductors, who are more active. They also compared postmen with a group of civil service executives, officers and clerks. Their conclusion was, "Men in physically active jobs have a lower incidence of coronary heart-disease in middle age than have men in physically inactive jobs. More important, the disease is not so severe in physically active workers, tending to present first in them as angina pectoris and other relatively benign forms, and to have a smaller early case-fatality and lower early mortality-rate."

The study of Spain and Bradess[4] of 1,000 consecutive deaths due to CAD corroborated the finding that sedentary occupational groups tend to have an earlier onset of death from CAD. Indeed, most studies seem to agree that sedentary activity is associated with a higher incidence of CAD and death at a younger age. This finding does not conclusively demonstrate, however, that lack of activity is a direct cause of the higher incidence of CAD.

There are a number of difficulties with these studies. In the first place, there may be factors other than exertion which differentiate the

groups. The person who would choose or be compelled to do heavy work undoubtedly has a different psychological makeup and social background than the person doing sedentary work. The food and smoking habits, and exposure to airborne dusts, are different in the two groups. Sedentary workers in certain industries, such as the railroad industry, tend to be accumulated in large cities, whereas the switchmen and section workers tend to live in smaller towns. There is some evidence that the rural areas have lower death rates than urban areas. Morris, Heady and Raffle[3] have presented evidence that bus drivers tend to be more obese than conductors, although this may be a reflection of the type of work. It is possible, however, that the obese tend to select sedentary jobs.

Even if it were proved that inactivity were related to CAD, it would not be possible to conclude from any evidence now at hand that the sedentary worker can decrease the risk of CAD or delay clinical onset by increasing his activity. It may well be that frenetic weekend physical fitness programs may be more harmful than helpful.

2. Exercise As An Immediate, Precipitating Cause of Acute Coronary Artery Thrombosis

There is a general impression that AMI occurs commonly in older men who attempt to clear their sidewalks of snow. The infarction is blamed on the excessive exertion, but usually this activity is performed by an elderly man after a heavy breakfast, in the extreme cold, so that identification of exercise as the precipitating cause is unwarranted. Over the last 30 years, a number of studies have shown that AMI occurs more often during rest than during or following exercise. A study of Phipps[5] in 1936 showed that only 40% of the patients had been performing some physical activity prior to the onset of the attack. Master et al,[6] in a study of 817 attacks of AMI in 555 patients, showed that about 40% of the attacks occurred while the patient was at rest or asleep; 18% occurred while the patient was walking, 14% during mild activity, 5% during moderate activity and only 2% during severe activity. In Spain and Bradess's[4] study of 410 cases, only 67 had a definite history of physical activity that could be classified as moderate to strenuous in the period immediately preceding the attack.

A problem arises in study of factors preceding acute AMI as to how an ordinary day is divided among sleep, sitting, walking, and heavier activities. Heavy exertion could well be a precipitating factor in acute AMI, but because most people never perform heavy exertion, this precipitating factor could appear to be rare because exertion is rare.

It is significant that a number of exercise studies have been performed on patients with known angina pectoris[7] without particular danger of AMI. In addition, innumerable Master's tests are performed on patients with suspected coronary artery disease with a very low mortality rate.

3. Exercise After Recovery from Myocardial Infarction

For some time it has been a general clinical impression that moderate exercise following recovery from a myocardial infarction is helpful, rather than harmful, provided cardiac failure and angina are not present.

This belief is now being put to the test by several investigations. Hellerstein et al[8] have reported 53 men with CAD, 39 of whom had myocardial infarctions and 14 angina pectoris (but not cardiac failure). They were subjected to a supervised graded, individualized exercise program two to three times weekly. Thirty-eight patients fully adhered to the program, nine adhered only partially and six did not adhere at all. The average follow-up was 19 months per individual. There were two deaths. There was objective improvement (exercise ischemic S-T displacement, heart rate, blood pressure, systolic tension-time index) in about 82% of those who fully adhered to the exercise program, 55% of those who partially adhered and 17% of those who did not adhere to the full exercise program.

The reasons why certain patients did not complete the program are not given, but one might ask whether they were in poorer physical condition to start with than those who did finish the program.

It seems proper to conclude from the clinical experience and studies performed that moderate or even heavy exercise is not harmful either in predisposing to CAD, in precipitating AMI or following recovery from AMI, provided the patient is not in heart failure and does not have angina pectoris. Indeed, the evidence is strong



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that moderate daily exercise is helpful in all chronic stages of coronary artery disease.

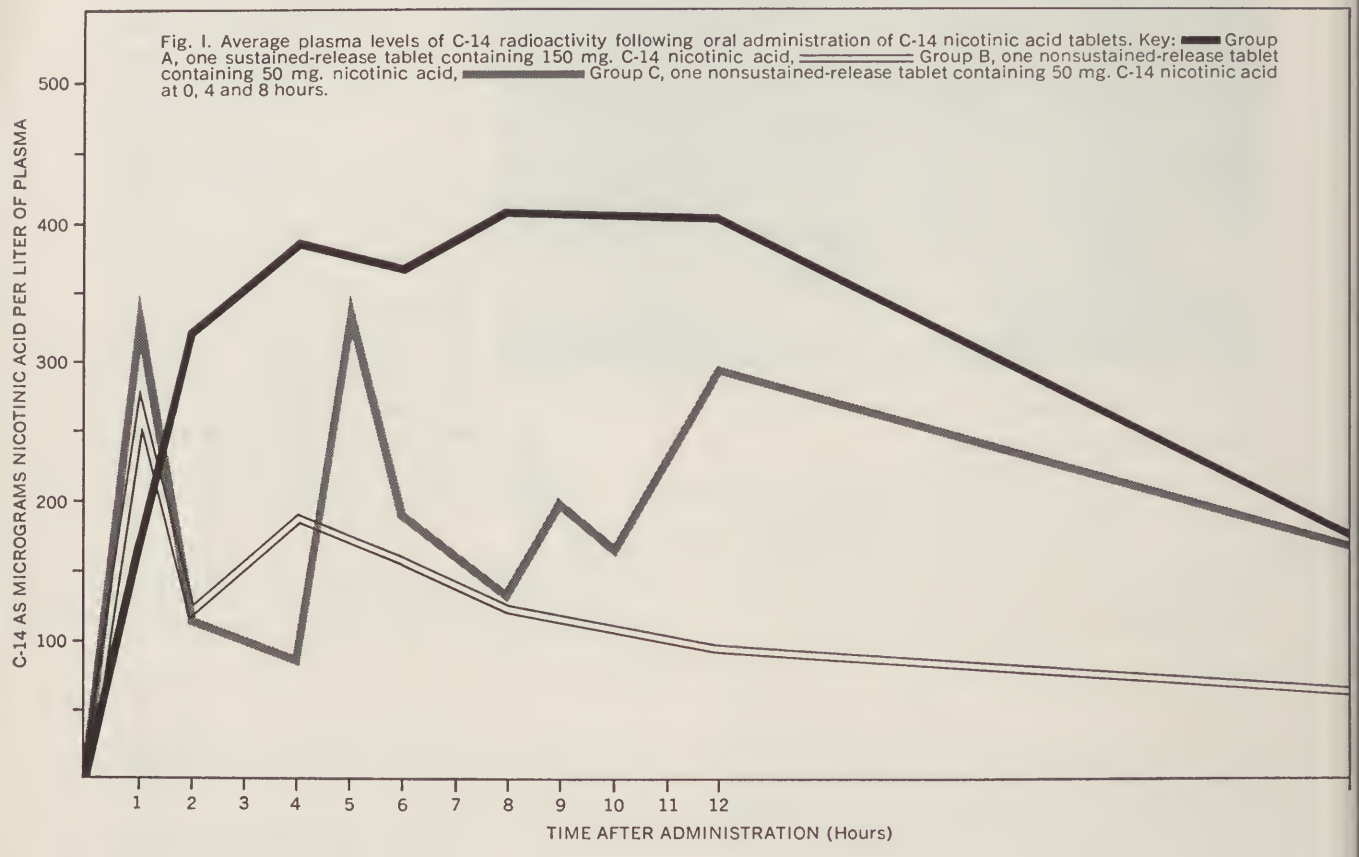
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There are other reasons besides possible effects on coronary circulation to urge gradual moderate exercise after an AMI. It is well established clinically that inactivity in the chronically ill is often accompanied by depression, passivity and withdrawal from normal life. Harrison[9] notes, "The experienced physician knows that of the various symptoms associated with disorders of the heart, fear causes more hours of human suffering than all of the others combined." The attitude of the physician toward exercise may do more to allay the patient's anxiety following an AMI than any amount of explanation and reassurance. During the early recovery from AMI, it is important, where possible, to start the patient on graded increase in activities so that he can see that he is improving. The speed of mobilization is not of primary importance. That is, a patient with a very severe AMI can be advanced in activity very slowly. If he sees some improvement weekly, it may be all that is necessary. To the less severely ill patient, daily increase in activity may be appropriate.

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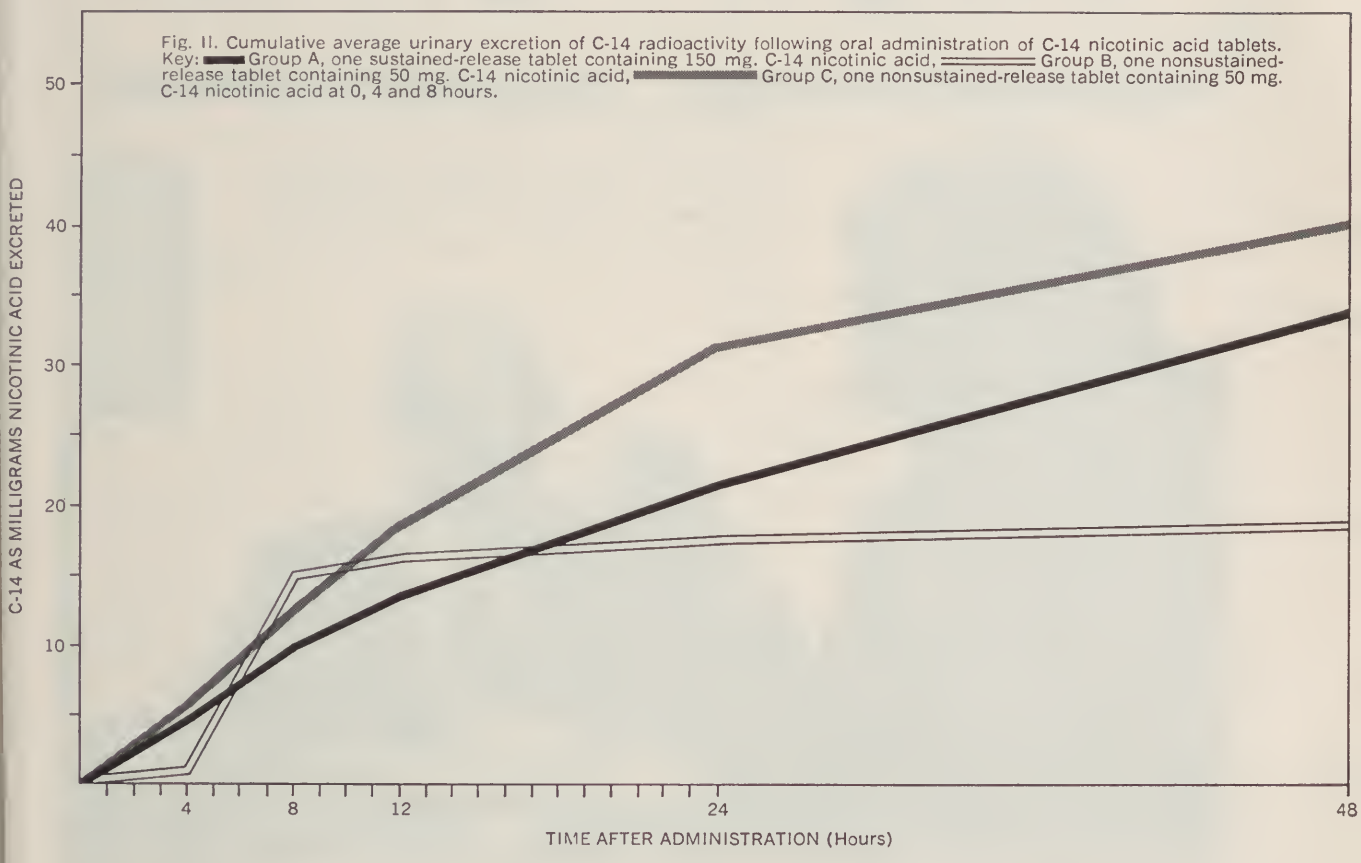
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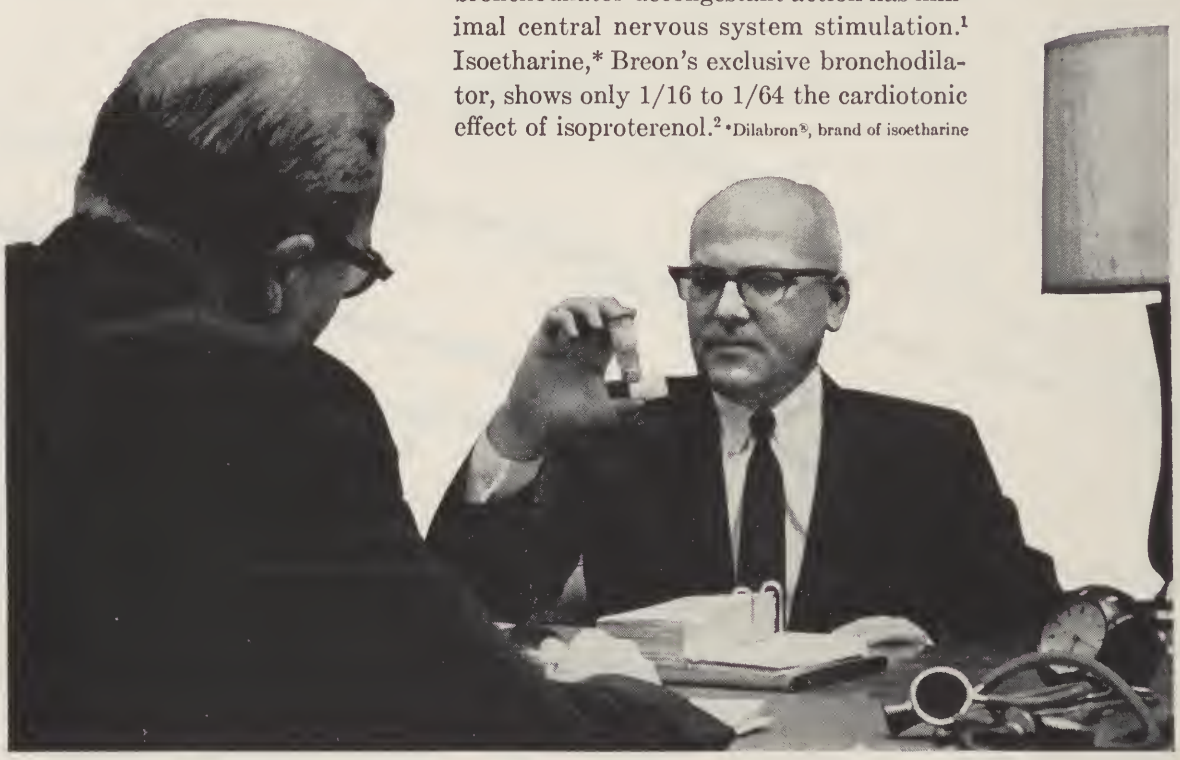
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RECOMMENDED DOSAGE: One or two inhalations with at least one minute between inhalations. Occasionally more may be required, however in most cases, inhalations need not be repeated more than every four hours. Dosage should be adjusted to the severity of the condition and to patient's response.

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References: 1. Spielman, A. D.: *Curr. Therap. Res.* 3:235 (June) 1961. 2. Herschfus, J. A.; Bresnick, E.; Levinson, L.; and Segal, M. S.: *Ann. Allergy* 9:769 (Nov.-Dec.) 1951.

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, *Commissioner*

HIGHLIGHTS

TYPHOID VACCINE

The State Health Department is now stocking only the monovalent typhoid vaccine. The use of the triple vaccine (typhoid with para A and para B) was discontinued following a report of the Advisory Committee on Immunization Practice of the Public Health Service that the effectiveness of paratyphoid A and B vaccines is not established and their use is not recommended.

Typhoid vaccine is recommended for those having intimate contact with carriers, for those involved in localized outbreaks, and for those travelling in foreign countries where typhoid fever is endemic.

Typhoid vaccine is no longer used on a mass scale except in rare community or institutional outbreaks. Thirty years ago, 300 to 500 cases were reported in Maryland each year, but since 1942 there has been a steady decline in the number of cases reported. During the last five years the figure has varied from 3 to 14 cases annually.

For adults and children over 10 years of age, the recommended dose of the monovalent typhoid vaccine is two 0.5 cc subcutaneous injections given at intervals of four or more weeks.

The dose for children 6 months to 10 years of age is 0.25 cc in each of two doses. Booster injections of 0.5 cc for adults and 0.25 cc for children, given subcutaneously, or 0.1 cc given intradermally, should be administered every three years.

DEER'S HEAD ACCREDITED

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals has approved the recommendation that Deer's Head State Hospital be accredited for the period of one year.

SCHOOL HEALTH

Added emphasis has been given to the school health program by the State Departments of Health and Education through the recent addition of school health educators to their staffs.

A Committee to Revise School Health Laws, composed of representatives from both State and local departments of health and education, and from the State Department of Mental Hygiene, has been organized to recommend changes in the existing laws to provide the nucleus of a sound school health program.

A newsletter, to be published jointly by the Departments of Health and Education, will be distributed three times a year, beginning in October. It will encourage discussion of current health issues involving the health of school-age children. The first issue will be devoted to Family Life Education.

SMOKING CLINIC

Under the leadership of Dr. Daniel Horn, Director of the National Clearinghouse for Smoking and Health, the Department is conducting four

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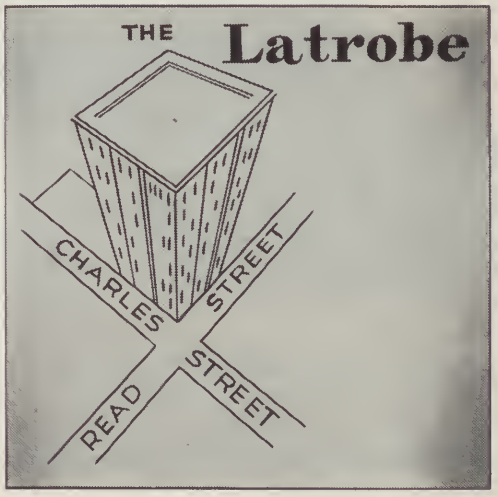
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The method includes a self-inventory designed to elicit reasons the individual smokes. One of the purposes of the program is to pretest this method of trying to help people stop smoking in a health department setting. Members of the staff of the Department of Mental Hygiene also have been invited to attend.

BALTIMORE CITY HEALTH DEPARTMENT

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1965 Birth Certificates Show Encouraging Trend In Prenatal Care

A study of birth certificates for 1965 by the City Health Department's Bureau of Biostatistics indicates encouraging results from the Department's efforts to reduce longstanding high infant death rates in the city, especially among the nonwhite segment of the population. The following notable gains were reported:

1. In 1965 there was increased utilization of existing health facilities for prenatal care. More women sought care and sought it at an earlier stage of pregnancy than in 1964.

2. On a city-wide basis the number of pregnant nonwhite girls 16 years and under was 888 in 1965, as compared with 834 in 1964. The proportion of these pregnant girls who sought prenatal care in the first third of pregnancy almost doubled (from 8.4% to 16.2%). Definite improvement was shown by all age groups of nonwhite women.

3. While the death rate for white infants in the first month of life remained at about the same level in 1964 and 1965, the death rate for nonwhite infants dropped by 13.5% over 1964. The greatest decline in infant deaths occurred in nonwhite infants whose mothers had prenatal care within the first three months of pregnancy; this group experienced a drop in death rate of 44.6%. A lesser decline of 18.7% was noted in nonwhite infants whose mothers sought care in the second three months of pregnancy. This comparison demonstrates most dramatically the vital importance of pregnant women seeing a doctor early in pregnancy.

4. There were 19,907 resident live births in 1965, as compared with 21,987 in 1964. The birth rate and the resident live births continued to decline at a pace greater than that of the national rates. White live births dropped by 10.8% and the nonwhite by 8.2%.

The Baltimore Maternity Center, the headquarters facility of Project 501, cared for 6,243 pregnant patients in 1965, as compared with 6,211 in 1964, an increase despite the 9.5% decline in resident live births in the same period.

The Baltimore Maternity and Infant Services Center, 211 West Lombard Street, is under the direction of Dr. Kathleen A. Swallow. The Center is open daily, 8:30 AM to 2:00 PM, Monday through Friday. Physicians may refer their needy pregnant patients to the Maternity Center for prenatal and follow-up care.

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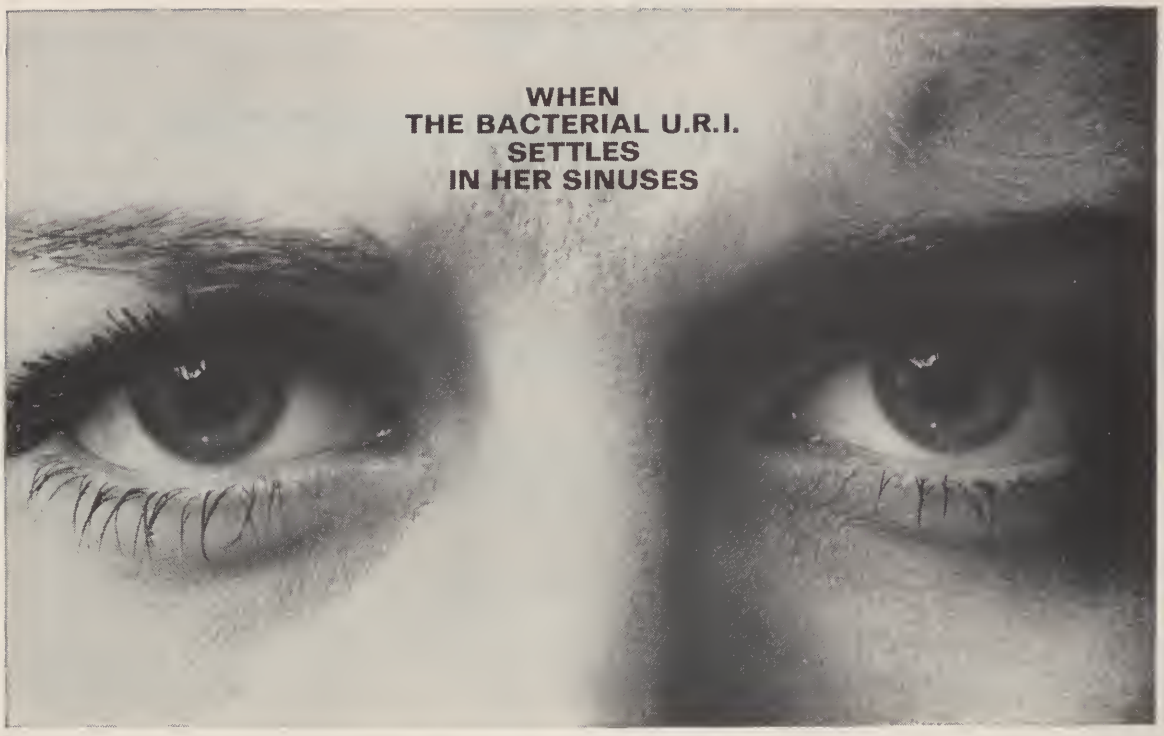
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Reference: 1. Roberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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THE SCHIZOPHRENIC PATIENT

Schizophrenia is the most frequently noted diagnosis in Maryland's psychiatric hospitals and clinics, with nearly one-fourth of all patients reported to have this disorder. In the state-operated hospitals, 46.2% of all beds are occupied by schizophrenics and they comprise 57.8% of all patients who have been hospitalized for five years or more.

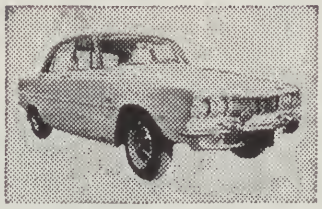
The Table shows the latest available data on the one-day prevalence of schizophrenic patients in all inpatient and outpatient facilities reporting to the Maryland Psychiatric Case Register by age and by major diagnostic subgroup. Paranoid and chronic schizophrenics, the two largest groups, accounted for 60% of these cases. Rates increase to a maximum between 45 and 64 years of age, after which they decrease slightly.

During a recent three year period (July 1, 1961-June 30, 1964), more than 14,000 Maryland residents (or one out of every 225) were reported to have had one or more treatment episodes for schizophrenia. The proportion of the total population under care was slightly higher for females than for males and considerably higher for non-whites than for whites. However, the highest rate was noted for white males between the ages of 35 and 44 who were separated from their wives, with more than two percent of these Maryland residents under treatment for schizophrenia.

The types of schizophrenia were first classified and described by Emil Kraepelin more than 50 years ago. A number of studies since that time have reported considerable variation in its frequency of occurrence. Available Register data for

		AGE				
SUBGROUP	TOTAL	5-14	15-24	25-44	45-64	65 And Over
Paranoid	2,217	—	58	885	947	327
Chronic	1,188	2	115	658	348	65
Catatonic	803	—	71	363	298	71
Hebephrenic	500	—	8	78	228	186
Acute	221	2	62	131	21	5
Childhood	41	24	17	—	—	—
Other	885	4	60	287	382	152
TOTAL	5,855	32	391	2,402	2,224	806
Rate Per 100,000 Estimated Population	168.9	4.4	74.6	262.7	338.2	326.7

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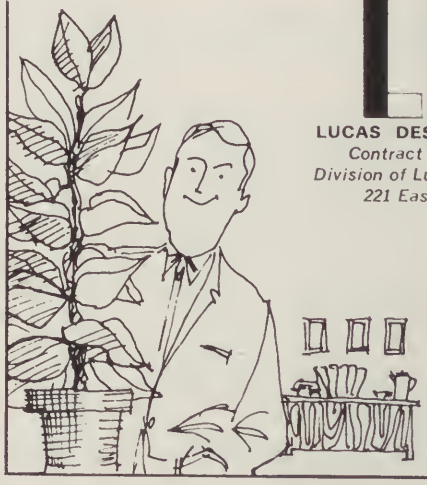


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Maryland indicate an annual incidence rate of approximately 50 (per 100,000 estimated population), or nearly 1,800 new cases per year. This number indicates that it is one of our major disease entities, particularly since it is frequently a chronic condition which was first observed at an early age. While psychotherapy, drugs and available supportive services have enabled increasing numbers of schizophrenics to function as family and community members, the continuing need is for expanded research related to the causes, prevention and management of this illness.

Doctor,

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mood elevation

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Anorectic
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Smooth appetite control plus mood elevation.

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Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



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Anorectic
Program

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Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



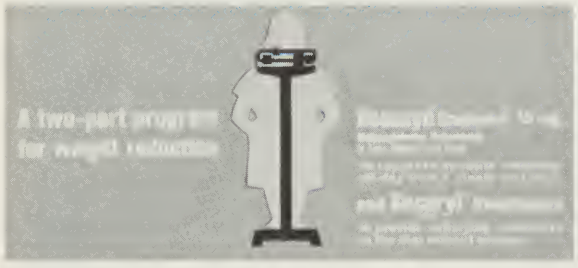
Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

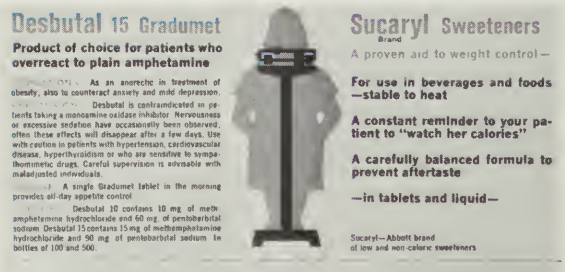


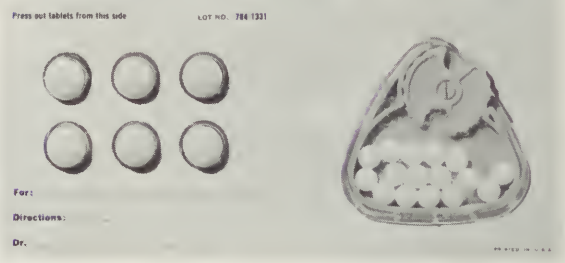
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CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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Sucaryl—Abbott brand of low and non-caloric sweeteners.

MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

SEMIANNUAL MEETING

The Maryland Association of Medical Assistants held its sixth semiannual meeting at the Stowaway Motel, Ocean City, Md, on Saturday, September 10, 1966.

Registration at 11:30 AM was followed at noon by the business meeting, which was conducted by Miss Betty Fern, president. The scientific sessions began at 2:45 PM with a welcoming address by Russell S. Fisher, MD. Dr. Fisher is Chairman of the Council of the Medical and Chirurgical Faculty, and Chief Medical Examiner of Maryland.



Betty Fern and Raymond M. Yow, MD

A. S. Hashim, MD, the guest speaker, talked to the medical assistants on "Pediatric Trends in Iraq." Dr. Hashim was graduated from the Medical College in Baghdad and interned in the Teaching Hospital there. He came to America in 1953 and had a medical fellowship at the Children's Medical Center in Boston, followed by a



A. S. Hashim, MD

year's pediatric residency in Columbus Children's Hospital. Since his certification by the American Board of Pediatrics in 1957, Dr. Hashim has been



MAMA OFFICERS

From left to right, Dorothy Hartel, corresponding secretary; Gertrude Gillum, vice-president; Betty Fern, president; Margaret Swank, vice-president of AAMA; John Komber, president; and Nell Chaney, president-elect.

practicing pediatrics in Cumberland.

"Maganga," a documentary film on the status of medicine in Africa, was presented at the conclusion of Dr. Hashim's talk.

The session was highlighted by the semiannual banquet at the Ship's Cafe. Raymond Yow, MD, advisor to MAMA from Salisbury, was the master of ceremonies and his wit proved to be delightful. Dr. Yow is a diplomate of the American Board of Urology and Fellow of the American College of Surgeons.

Raymond Atkins, MD, advisor to MAMA from Baltimore, was unable to attend this meeting and his absence was keenly felt because of the many contributions in time and effort which he has made during past meetings.

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What to Do About Christmas Gifts

WILBURN L. McCLURE, JR.

Each year, about this time, the same familiar questions arise regarding Christmas giving. Here is a review of some typical questions accompanied by recommended solutions.

Q. "Should I give my office staff a personal gift or cash?"

A. "If you give an employee cash, it does not come within the $25 annual gift limitation rule. If you wish to deduct the amount given as a gift, however, it must be reported on the recipient's W-2 slip for income tax purposes. Gifts of tangible personal property, such as a watch, portable typewriter, tape recorder, or radio, costing no more than $100 and given for 'loyalty' or 'devotion to duties' are not included in figuring the $25 limitation.

"Whatever you decide, make your decision early. If it is to be a gift, try to learn what she really needs. If it is to be cash, give it at least two weeks before the holiday. It may be the answer to her gift budget, and she won't die of anticipation."

Q. "What should I do about gifts to interns, residents, and nurses who assist me?"

A. "Gifts for an intern or resident sometimes present a problem. Practically speaking, there could be no finer or more useful gift than a certificate to one of the better local restaurants. Even if he should receive more than one such gift, the odds are that each one will be thoroughly enjoyed and probably at a place he might not otherwise go because of his limited time and budget.

"For the nurse, again a gift certificate, but this time from one of the large department stores where she can purchase the toiletries or other items personally needed but not found under the Christmas tree."

Q. "What should I give to referring colleagues, patients, and friends that is a little different from the usual?"

A. "Gifts to referral sources should be useful and practical. Clocks, elaborate ash trays, brief cases, transistor radios, and electric knives, can openers, and tooth brushes are but a few of the long list of gifts almost anyone would like to receive."

Q. "What are the limitations on professional gifts under the present tax rules?"

A. "Deductions for gifts to referring colleagues, patients, and friends, as well as to interns, residents, and nurses are limited annually to $25 a person. The $25 limitation affects a partnership as well as a solo practi-

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Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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tioner in that the partnership cannot exceed $25 a person annually, regardless of the number of partners. You can, of course, give a more expensive gift to valued, helpful friends, but you may deduct no more than $25. These rules do not apply to employees."

Q. "I don't believe in giving gifts. What about entertaining instead?"

A. "Entertainment is important at this time of year. Entertaining small intimate groups, especially in your home, adds a personal warmth to the season. Sunday brunch or a late evening dinner are ideal occasions. (You may wish to review, "What You Should Know About Entertaining Colleagues," *Maryland State Medical Journal*, May, 1966, page 155.)

So that you may achieve the true art of giving and entertaining, keep the following thought in mind: "Have I included everyone on my list so that I will not offend a single person?"

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Woman's Auxiliary
MARYLAND
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W A M C F

NOVEMBER, 1966

Semiannual Meeting

The Semiannual Meeting of the Woman's Auxiliary to the Faculty, concurrent with the Semiannual Meeting of the House of Delegates, was held Friday morning, September 9, in the Diplomat Motor Hotel, Ocean City, Md. Mrs. Archie R. Cohen, president of the Auxiliary, presided at the meeting, which was opened with greetings from Manning W. Alden, MD, the Med-Chi Advisor.

At the conclusion of the business session, Carolyn S. Pincock, MD, addressed the members on the subject of "Aspects of Adolescent Medicine Through the Eyes of the Physician and his Wife." Dr. Pincock, who is an Associate Attending at the Children's Hospital in Washington, DC, talked primarily of a practical approach to such adolescent problems as health, personality, and family interrelationships.

October A Busy Month for Auxilary Leaders

The Woman's Auxiliary is constantly seeking ways to help physicians meet the health needs of people in their communities. In October, the Maryland Auxiliary leaders traveled to Chicago and to New York City to acquire knowledge of other programs for the advancement of medicine and public health.

Those who attended the 1966 Fall Conference of the Woman's Auxiliary to the American Medical Association, from October 2 to 4 at the Drake Hotel in Chicago, included Mrs. William S. Stone, Baltimore, a national director of the Woman's Auxiliary to the American Medical Association; Mrs. John E. Baybutt, Easton, Eastern regional chairman for AMA-ERF; Mrs. Archie R. Cohen, Clear Spring, president of the Woman's Auxiliary to the Medical and Chirurgical Faculty; and Mrs. Wallace H. Sadowsky, president-elect of the Woman's Auxiliary to the Faculty.

The Hon. Vu Van Thai, ambassador to the U.S. from South Vietnam, was the featured Conference speaker. He highlighted the impact of medical programs on his country's civilian population. Appearing with him were Norman Hoover, MD, Mayo Clinic, who described his experiences in Vietnam, and Ernest B. Howard, MD, AMA assistant executive vice-president, who described the association's Vietnam projects.

Other program features included presentations on Title XIX of the Medicare law by: Charles L. Hudson, MD, AMA president; Ellen Winston, PhD, a commissioner of the Health, Education, and Welfare Department; Mr. Howard Hassard, executive director of the California Medical Association; and Henry I. Fineberg, MD, executive vice-president of the Medical Society of the State of New York.

Another speaker was Dean W. Roberts, MD, executive director of the National Commission on

Community Health Services, Inc. His topic was "Health Is a Community Affair." Additional program topics were "Action Programs for Women" and such direct service auxiliary projects for the homebound and elderly as homemaker service, meals-on-wheels and Volunteer Friendly Visitor training.

On Tuesday night conference members attended a dinner sponsored by the American Medical Political Action Committee, where the featured speaker was Congressman Donald Rumsfeld, R, 13th Congressional District, Illinois. Also scheduled during the conference were regional membership dinners and discussion sessions on parliamentary procedure and press relations.

The National Eastern Regional Workshop at the City Squire Motor Inn, New York City, on October 10 and 11 was sponsored by the National Auxiliary, and conducted for the state auxiliary presidents, presidents-elect and chairmen of the following committees: AMA-ERF, Community Service, Health Careers, Legislation, Membership, and Mental Health. Those from Maryland who attended were Mrs. Cohen, Mrs. Sadowsky, Mrs. Baybutt, and Mrs. DeWitt E. DeLawter, Bethesda, the state chairman for Legislation in the Auxiliary.

Auxiliary Officers

The officers and committee chairmen of the Woman's Auxiliary to the Medical and Chirurgical Faculty for the year ending April, 1967, are listed below for the benefit of non-members who would like to join the Auxiliary and present members who are not currently participating in any of its activities. All are urged to select a field of interest and volunteer their services to the appropriate committee chairman, or to direct questions and suggestions to one of the officers.

President: Mrs. Archie R. Cohen, Clear Spring, 842-2838
President-elect: Mrs. Wallace H. Sadowsky, Havre de Grace, WE9-1918
1st Vice-president: Mrs. M. McKendree Boyer, Damascus, CL3-2122
2nd Vice-president: Mrs. Raymond M. Yow, Salisbury, PI2-1381
3rd Vice-president: Mrs. Raymond C. V. Robinson, Baltimore City, DR7-8777
4th Vice-president: Mrs. Carlton Brinsfield, Cumberland, 724-5820
Treasurer: Mrs. George S. Malouf, Hyattsville, 277-5885
Recording Secretary: Mrs. Robert A. Reiter, Baltimore City, LO6-2718
Corresponding Secretary: Mrs. Howard N. Weeks, Hagerstown, 739-2420
Parliamentarian: Mrs. Martin E. Strobel, Baltimore County, 833-3242

Committee Chairmen

AMA-ERF: Mrs. G. Overton Himmelwright, Cumberland, 724-0731
Community Service: Mrs. M. McKendree Boyer, Damascus, CL3-2122
Convention: Mrs. Delmas D. Caples, Baltimore County, 833-4699
Mrs. Martin E. Strobel, Baltimore County, 833-3242
Councilor to Woman's Auxiliary to the Southern Medical Association: Mrs. Raymond C. V. Robinson, Baltimore City, DR7-8777
Disaster Preparedness: Mrs. John R. Smith, Jr., Centreville, 758-0734
Doctor's Day: Mrs. Raymond C. V. Robinson, Baltimore City, DR7-8777
Editor, Auxiliary Page, Maryland State Medical Journal: Mrs. Harry L. Berman, Ellicott City, HO5-1422
Finance: Mrs. O. D. Sprecher, Jr., Hagerstown, 733-7118
Health Careers: Mrs. Raymond M. Yow, Salisbury, PI2-1381
Historian: Mrs. John Baybutt, Easton, 822-0811
Hospitality: Mrs. David S. Clayman, Hyattsville, WA7-2002
International Health Activities: Mrs. Leland Ransom, Cumberland, PA2-8018
Mrs. Carlton Brinsfield, Cumberland, 724-5820
Legislation: Mrs. DeWitt E. DeLawter, Bethesda, OL2-2506
Student Liaison to Woman's Auxiliary to Student AMA: Mrs. Albert E. Goldstein, Baltimore City, BE5-1341
M.D.'s WIFE: Mrs. Sullins G. Sullivan, Baltimore City, VA5-6422
Members-at-large: Mrs. Elmer G. Linhardt, Annapolis, 263-2156
Membership: Mrs. Wallace H. Sadowsky, Havre de Grace, WE9-1918
Mental Health: Mrs. Irving J. Taylor, Baltimore City, HU6-4066
Newsletter: Mrs. Samuel R. Wells, Mt. Wilson, HU6-7676
Press and Publicity: Mrs. Robert A. Reiter, Baltimore City, LO6-2718
Representative to Med-Chi Public Relations Committee: Mrs. H. Leonard Warres, Baltimore City, FL8-1151
Revisions and Resolutions: Mrs. John G. Ball, Bethesda, OL2-3200
Safety: Mrs. John R. Smith, Jr., Centreville, 758-0734

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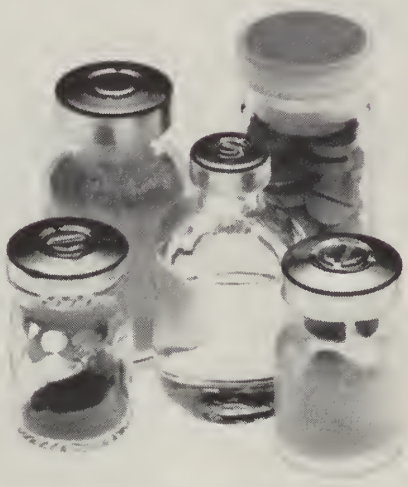
Montgomery County Auxiliary

The monthly luncheon meeting of the Woman's Auxiliary to the Montgomery County Medical Society was held on Tuesday, October 18, at the Linden Hill Restaurant. Mrs. Norman Oliver and Mrs. William Aud were co-chairmen of the luncheon. Mr. Ernst S. Johnston, the guest speaker, addressed the group on the subject of "Public Relations of the Medical Profession."

Mrs. Francis Mayle is chairman of the auxiliary's annual luncheon and fashion show, to be held this year on December 7 in the Regency Ballroom of the Shoreham Hotel in Washington, DC. Proceeds from this event will go toward scholarships for doctors and nurses at the University of Maryland School of Medicine.

against the usual gram-negative urinary pathogens

Why use five...where **one** will do?



In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)...and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. *272*:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

Full information is available on request.

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The "Socio-geographic" mystery

Why is one man's gastric ulcer another man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same geographic areas there are interesting variations. An Englishman's ulcer depends on his social standing—professional men suffer with duodenal ulcers, while workingmen have more of the gastric variety. In southern India the pattern is reversed. Here, duodenal ulcers are common among laborers and agricultural workers and rare among the upper classes.

Investigators are exploring every possible theoretical avenue in their search for the cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, one that is generally acknowledged to be of primary importance is hypersecretion of gastric acid.[3-8] Or, as one author states it: "The medical management of peptic ulcer pharmacologically is, in the final analysis, concerned largely with the effective inhibition of peptic activity."[3]

Robinul (glycopyrrolate) provides potent, rapid, specific antisecretory action confirmed by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] Relieves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, and effectively counteracts gnawing pain, preprandial midepigastric pain, belching and other ulcer symptoms.[7] Suppression of nocturnal pain is "outstanding."[13] Maximally effective doses may be given with minimal side reactions, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

No matter what the ulcer theory... the fact is that

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(glycopyrrolate)

promotes the essential ulcer-healing environment

A. H. ROBINS

(brief summary follows)

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Indications: In addition to its primary indications for duodenal and gastric ulcer, Robinul (glycopyrrolate) is indicated for other GI conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.
Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.
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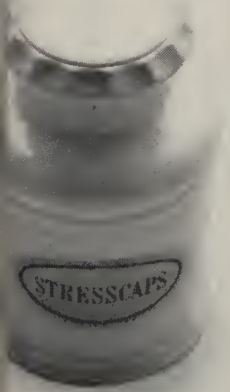
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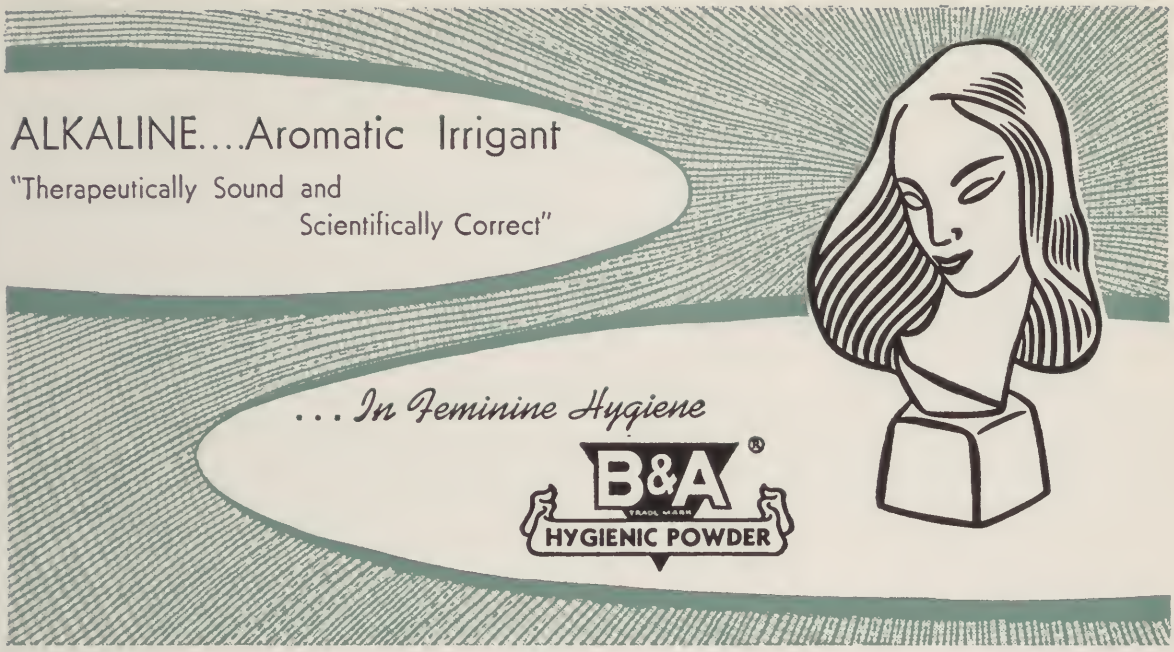
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3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

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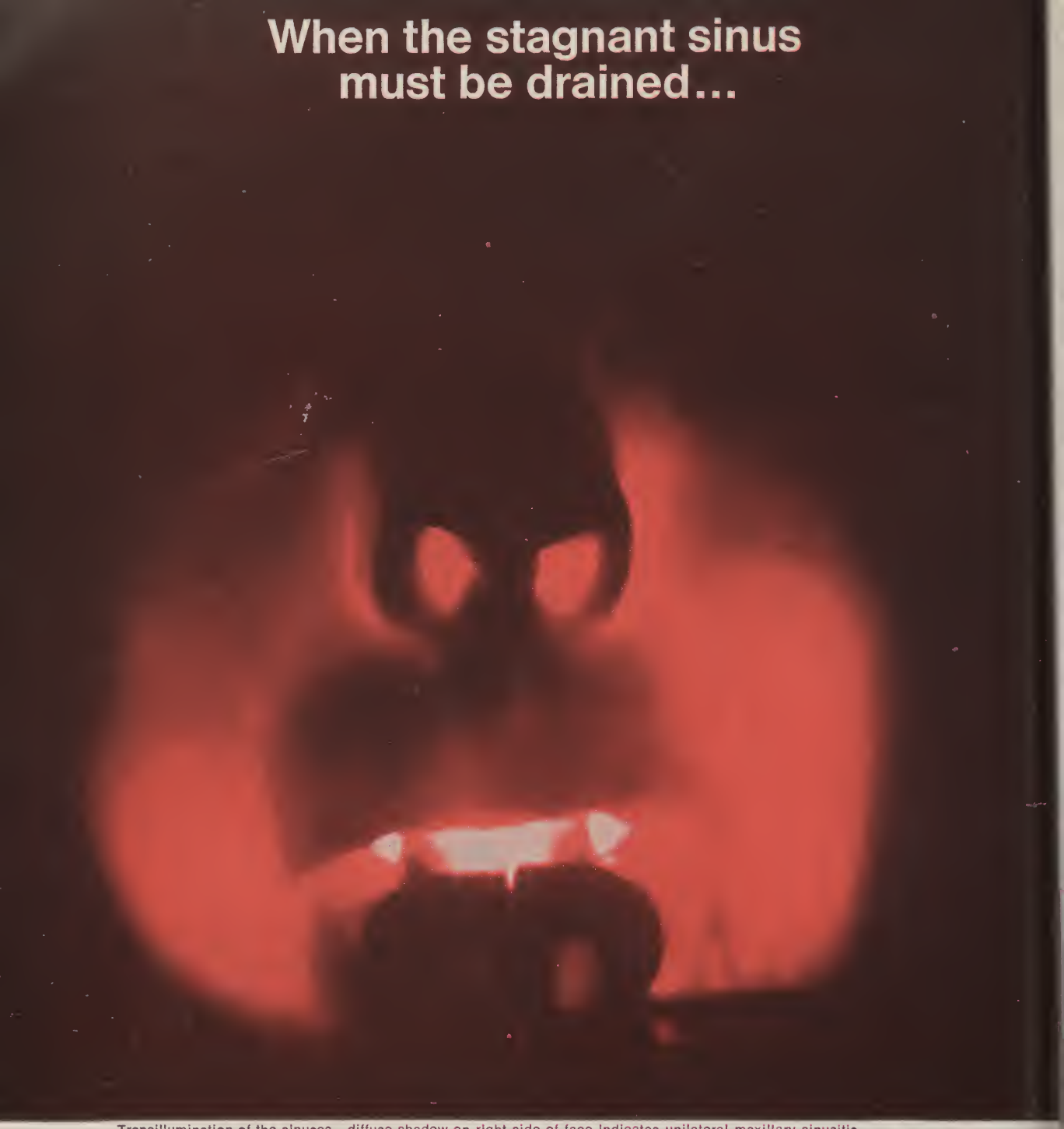
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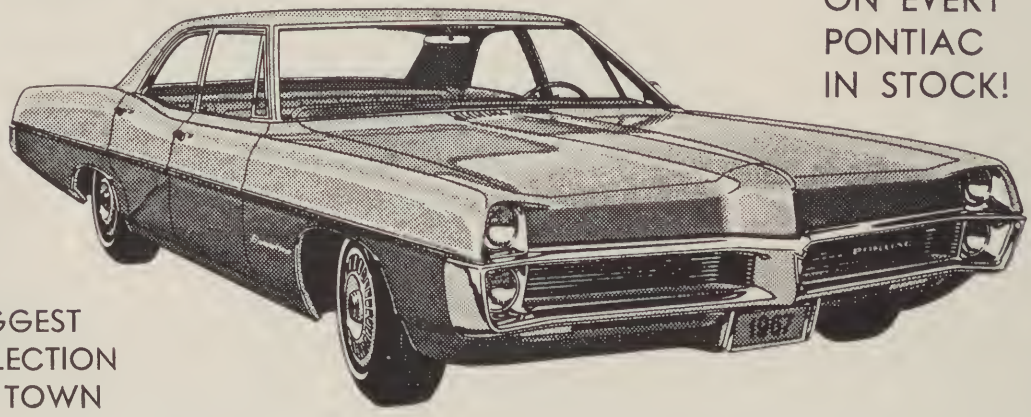
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State of Maryland Department of Health

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State of Maryland Department of Mental Hygiene

The Mentally Retarded in Psychiatric Hospitals 131

Solutions to Business Problems in Daily Medical Practice

Annual Business Review 135

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*Multiple of adult Minimum Daily Requirement supplied.
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Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

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MEDIC

FRIDAY POSTGRADUATE PROGRAMS

(See page 145 for list of locations where MEDIC programs may be heard)

January 6, 12:30 PM

Use of Drugs and Alcohol and Their Relation to Automobile Accidents

Russell S. Fisher, MD, Professor of Forensic Pathology, University of Maryland School of Medicine.

and

Henry C. Freimuth, MD, Associate Professor of Forensic Pathology, University of Maryland School of Medicine.

January 13, 12:30 PM

Arteriosclerosis and Diet

Benjamin M. Baker, MD, Professor of Medicine, The Johns Hopkins University School of Medicine.

January 20, 12:30 PM

Organ Scans

William A. Newman, MD, and Albert P. Marsh, MD, Radiology Department, Sacred Heart Hospital.

January 27, 1 PM

Differential Diagnosis of Growth Retardation and Sexual Infantilism in Adolescence

Robert M. Blizzard, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.

February 3, 12:30 PM

Mental Retardation, Pseudo-Retardation and School Failure

Raymond L. Clemmens, MD, Associate Professor of Pediatrics, University of Maryland School of Medicine.

Appropriate AAGP credit is given for every MEDIC program attended.

BALTIMORE CITY MEDICAL SOCIETY

January 6, 8:30 PM

The Present Status of Renovascular Hypertension

Thomas B. Connor, MD, associate professor of medicine, and head, division of Endocrinology and Metabolism, Department of Medicine, University of Maryland School of Medicine.

John D. Young, Jr., MD, professor of urology, and head, Division of Urological Surgery, University of Maryland School of Medicine.

Question and Answer Period

Acceptable for 2 hours' Category I Credit by the American Academy of General Practice

1211 Cathedral Street, Baltimore

MARYLAND PEDIATRIC SOCIETY

January 10, 8:00 PM

Gordon B. Avery, MD, Children's Hospital, Washington, DC

Topic to be announced

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AMERICAN COLLEGE OF SURGEONS

February 27-March 2

Sectional Meeting for Doctors and Nurses

In addition to general surgery, there will be programs in the specialties of gynecology-obstetrics, neurosurgery, ophthalmology, orthopedics, plastic, proctology, thoracic, urology and a special full day devoted to trauma.

Nurses and Fellows of the College pay no registration fee; non-Fellows pay $25.00.

Americana and Hilton Hotels, New York, NY

For information, write ACS, 55 East Erie Street, Chicago, Ill, 60611

MARYLAND SOCIETY OF ANESTHESIOLOGISTS

January 3, 5:30 PM

Non-Rebreathing Systems

M. Jack Frumin, MD, attending anesthesiologist, The Mount Sinai Hospital, New York.

1211 Cathedral Street, Baltimore

AMERICAN MEDICAL ASSOCIATION

January 22-23

The First National Congress on the

SOCIO-ECONOMICS OF HEALTH CARE

Palmer House, Chicago

AMERICAN COLLEGE OF PHYSICIANS POSTGRADUATE COURSES

The following courses ore made possible by the generous cooperation af the directors ond institutions involved. Tuition fees: Members, $60.00; Nonmembers, $100. Registration forms and requests for informotion are to be directed to: Edword C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philodelphia, Po. 19104

JANUARY 16-20

Basic Mechanisms of Renal Disease

Carnell University Medical Center, and New York Haspital, New York, NY; E. Lavell Becker, MD, FACP, and George W. Frimpter, MD, FACP, Co-directors.

JANUARY 23-27

Current Concepts in Blood Disease

University of Miami School of Medicine to be held at the Fountainebleou Hotel, Miami Beoch, Fla; William J. Harringtan, MD, FACP, Director.

JANUARY 30-FEBRUARY 3

Newer Aspects of Experimental and Clinical Allergy

Horvard University Medical School, to be held at the Sheraton-Boston Hatel, Boston, Mass; Francis C. Lawell, MD, FACP, Director; Sidney Leskowitz, PhD, ond K. Fronk Austen, MD, FACP, Co-directors.

FEBRUARY 6-10

Biochemical Lesions in Internal Medicine

Woshington University School of Medicine, St. Louis, Mo; Carl V. Moore, MD, FACP, Sal Sherry, MD, FACP, ond Williom Daughaday, MD, Co-directors.

MARYLAND EAR, NOSE AND THROAT SOCIETY

January 10

Nasal Pathology and Systemic Illness

Maurice H. Cattle, MD, professor and heod, Department of Otolaryngology, University of Chicago School of Medicine.

1211 Cathedral Street, Baltimore

HEART ASSOCIATION OF MARYLAND

January 25

KICK-OFF LUNCHEON

Emerson Hotel, Baltimore

February 26

Heart Sunday

MARYLAND PSYCHIATRIC SOCIETY

January 26

Annual Dinner

Sheraton-Belvedere Hotel, Baltimore

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Postgraduate Courses

DERMATOLOGY

January 19, 1967, Fee $15.00

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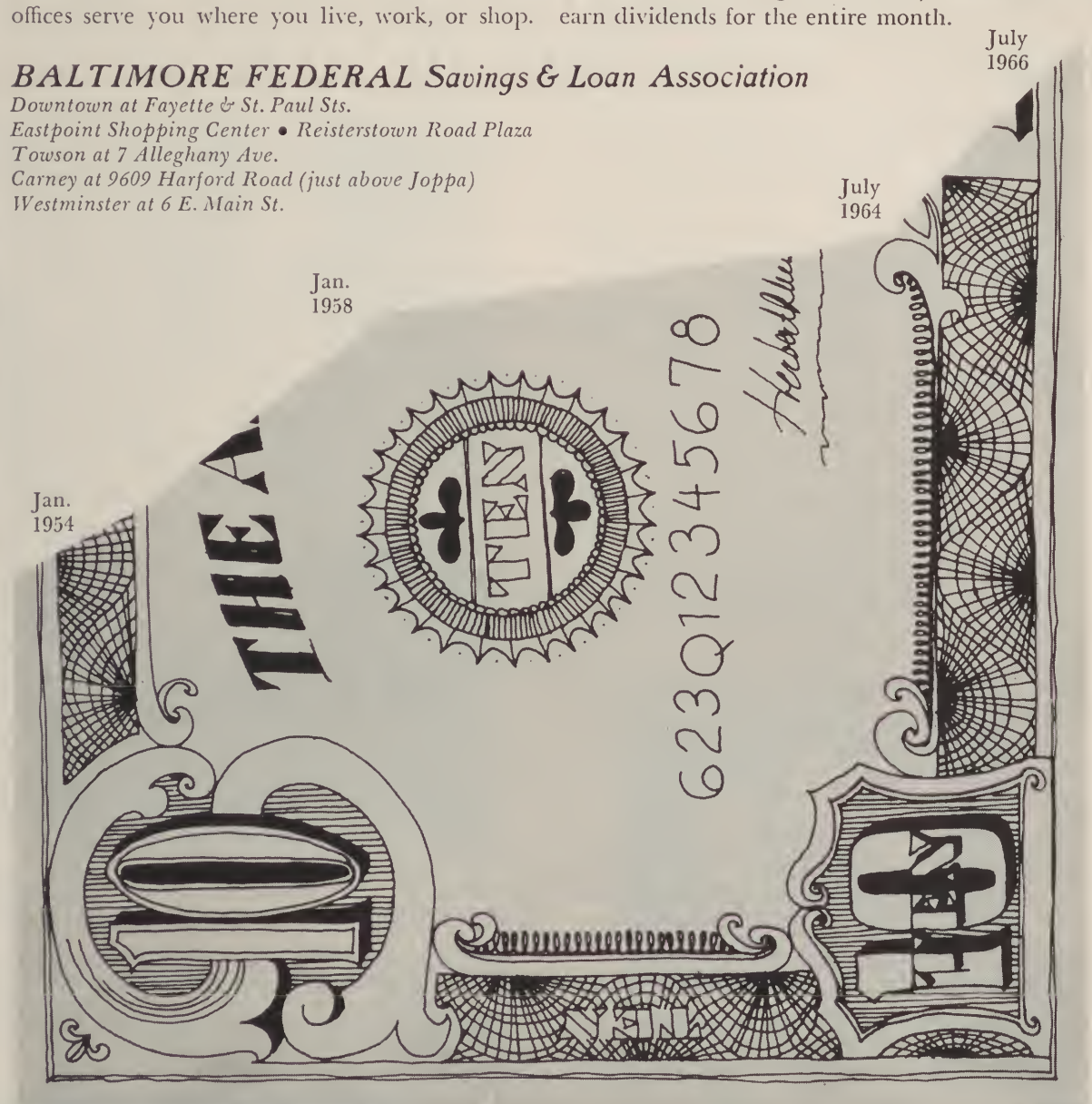
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JOHN SARGEANT — EXECUTIVE SECRETARY

EXECUTIVE COMMITTEE, NOVEMBER 3

1. The minutes of the September 9, 1966, House of Delegates meeting were adopted as published and in accordance with the Standing Rules of the House of Delegates.

2. Authority was granted for the publication of laws, rules and regulations with which physicians must comply, at a cost not to exceed $500.

3. J. T. H. Johnson, MD, was appointed as a member of the Advisory Committee to the Governor's Study Group on Vocational Rehabilitation, as a replacement for A. Gibson Packard, MD, who found it necessary to resign from this position.

4. The following appointments were approved for recommendation to the Commissioner of Motor Vehicles as members of the Medical Advisory Board of the Department of Motor Vehicles: Elijah Saunders, MD, internist; Charles E. Silberstein, MD, orthopedist; and John Edward Gessner, MD, physical medicine and rehabilitation. Drs. Saunders and Silberstein are from Baltimore City and Dr. Gessner from Baltimore County.

5. Following discussion for which William G. Speed, III, MD, chairman of the Fee Schedule Committee, was present, the Committee authorized the employment of an Actuarial Consultant to determine how the Health Department arrived at its Title XIX program figures for medical care items; to check the accuracy of those figures; and, if necessary, to advise the Faculty as to how correct data can be obtained. An expenditure of up to $2,000 for this project was approved, with the proviso that additional funds may be requested if necessary.

6. Eleven members of the Faculty were selected for appointment to the Physicians' Review Committee, Blue Cross, either as replacements or reappointments, and three were designated as available alternates.

7. The Executive Secretary reported receipt of an unsatisfactory reply to a letter he had written to the Maryland Hospital Commission asking whether or not it would endorse certain principles set forth in a report of a Survey of Hospital Facility and Service Needs for the State of Maryland by the firm which conducted the survey. The Committee voted unanimously for pursuit of the matter with the understanding that these principles were at variance with the feelings of the medical profession.

8. Approval was granted the Executive Secretary to serve in the following capacities: member, Board of Directors, Maryland Health Fair, Inc.; president, Mid-Atlantic Chapter, American Medical Writers Association; representative of the Board of Health and Mental Hygiene on the Board of Directors of the Hospital Cost Analysis Service, Inc.

9. Copies of a report of payments by Blue Shield to Hospital Educational Funds through June 30, 1966, were distributed for the information of Committee members.

10. Acting upon the report, in an anonymous letter, that compulsory assessment of medical staff members exists at St. Joseph

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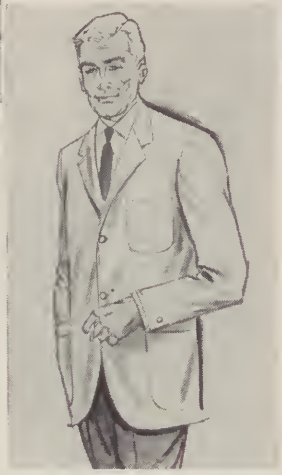
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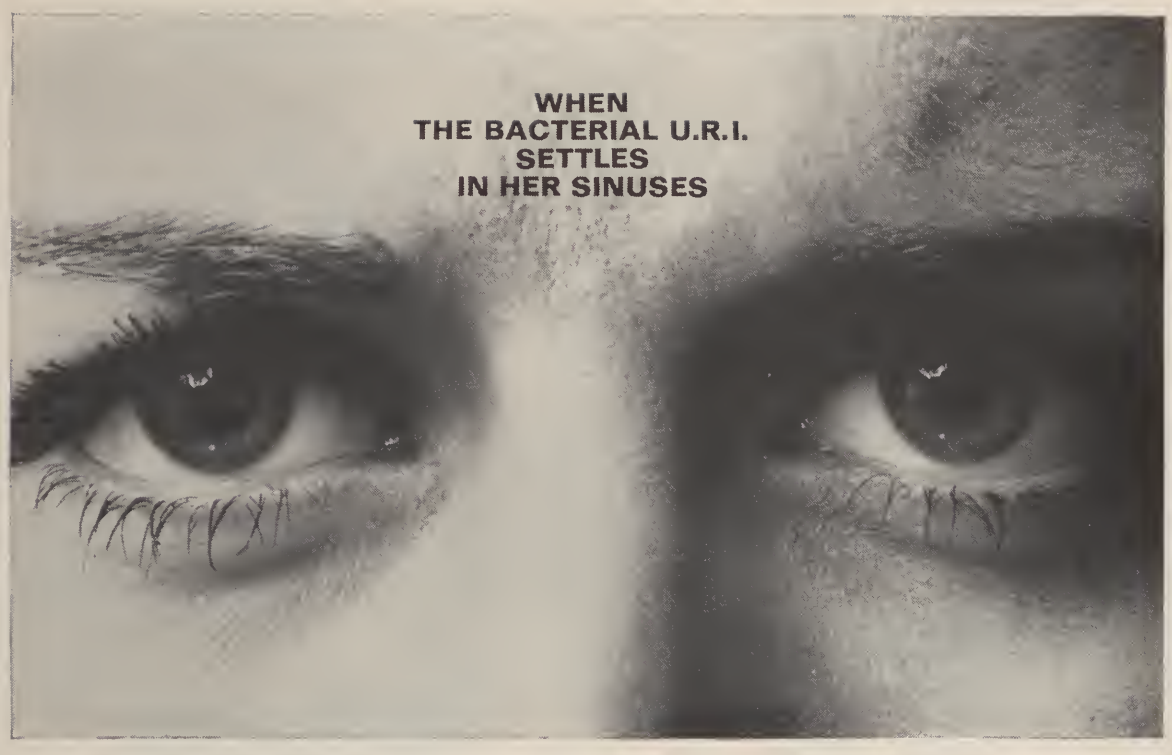
Hospital and at the Maryland General Hospital, the Committee voted to ascertain the accuracy of the information.

11. The reappointment of Kent E. Robinson, MD, as Faculty representative on the Advisory Council on Mental Hygiene was approved.

12. The Committee approved the appointment, suggested by the Subcommittee chairman, of J. Roy Guyther, MD, Mechanicsville, as a member of the Subcommittee of the Advisory Council for Higher Education.

13. The Committee was informed that Leonard Flax, MD, had filed an appeal of the Committee's decision of October 6 with the Judicial Council of the American Medical Association.

14. Russell A. Nelson, MD, joined the meeting to enlighten the Committee on the Johns Hopkins Hospital plan to bill government agencies for services rendered by Assistant Physicians (formerly Senior Residents). Dr. Nelson explained that the latter are licensed to practice medicine in Maryland, are fully qualified to receive payments under Title XVII, Part B, of the Medicare program, and are legally permitted to do so provided that their salaries are not included in the costs reimbursed under Part A, Title XVIII. There was extensive discussion of far-reaching effects of a system whereby the Assistant Physicians would be paid on a fee-for-service basis and would assign such funds to the hospital. Inasmuch as final regulations on payments for in-hospital medical care of patients have not been issued, it was acknowledged that the question of how such payments would be handled could not be answered at present.



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Warning—If renal impairment exists, even usual doses may lead to liver toxicity. Under such conditions, lower than usual doses are indicated and if therapy is prolonged, tetracycline serum level determination may be advisable. Hypersensitive individuals may develop a photodynamic reaction to natural or artificial sunlight during use. Individuals with a history of photosensitivity reactions should avoid direct exposure while under treatment and treatment should be discontinued at first evidence of skin discomfort.

Precautions—Some individuals may experience drowsiness, anorexia, and slight gastric distress. If excessive drowsiness occurs, it may be necessary to increase the interval between doses. Persons on full dosage should not operate any vehicle. Use may result in overgrowth of nonsusceptible organisms. If infections appear during therapy, appropriate measures should be taken. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Infections caused by beta-hemolytic streptococci should be treated for at least 10 full days to help prevent rheumatic fever or acute glomerulonephritis. Use of tetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect has been observed in usual short treatment courses.

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EXECUTIVE SECRETARY'S NEWSLETTER

December, 1966

EMINDER ON BILLING

The State Health Department advises that some physicians are not billing for medical care patients at the usual, customary and reasonable fees as recommended by the House of Delegates at the Ocean City meeting this year.

The Commissioner has requested this be brought to the attention of all members so they may comply with the ruling of the House of Delegates. Payments will be made at the current schedule, but this additional information will assist the Health Department in its collecting of data for payments when sufficient funds are appropriated for implementation of the usual, customary and reasonable concept.

CHILD ABUSE LAW

The attention of all physicians is brought to the Child Abuse Law, which requires their reporting of suspected child abuse cases to the local welfare department, within 24 hours of the treatment of the child. For cases seen at the hospital, the responsibility lies with the Hospital Administration.

NEW SMALLPOX CERTIFICATES

New Smallpox vaccination certificates go into use for vaccinations performed on and after January 1, 1967. The new certificate requires the indication as to whether a freeze-dried or liquid vaccine was used, as well as the origin and batch number of the smallpox vaccine.

Current certificates authenticated prior to January 1, 1967, will continue in use until they expire.

RESOLUTIONS FOR ANNUAL SESSION

Resolutions for consideration at the Faculty's Annual Meeting should be received in the Faculty office by:

WEDNESDAY, FEBRUARY 22, 1967

The Reference Committee will meet to consider the resolutions received on Wednesday, March 29, 1967, at 8:00 p.m., in the Faculty building, 1211 Cathedral Street, Baltimore.

NEWS NOTES

Selvin Passen, M.D., Baltimore, has joined the offices of Drs. Guerin, Kime and Sherrer for

the practice of Laboratory Medicine

Milton Markowitz, M.D., Baltimore, has been named President of the Heart Association of Maryland.

Ulgan I. Sila, M.D., Baltimore, has announced the opening of her office for the practice of Pediatrics at 3100 St. Paul Street.

Abraham Genecin, M.D., Baltimore, is the new President of the Maryland Society of Internal Medicine. Other officers include: John C. Harvey, M.D., President-elect; Barnett Berman, M.D., Secretary-Treasurer.

New Junior members of the American Society of Anesthesiology include: Harry Cohen, M.D., Martino M. Almogela, M.D., Simeon Boongaling Alvaran, M.D., Baltimore; and Fredric Stuart Taylor, M.D., Bethesda.

A new Fellow of the American College of Anesthesiology is Y. Victor Kent, M.D., of Baltimore.

New officers of the Maryland Orthopedic Society include: A. Gibson Packard, Jr., M.D., President; George N. Austin, M.D., President-elect; and Elroy Young, M.D., Secretary-Treasurer.

RARE BOOK OFFER

Mr. Stanley S. Slotkin, Founder and Chairman of the Board of Abbey Rents, is making available to physicians in Maryland pages from rare books held in his personal antiquarian library. The pages are from rare Medical and Biblical texts.

Copies may be obtained through Abbey Rents office in Baltimore, either by telephone or in person. There is no obligation.

John Sargeant

Executive Secretary

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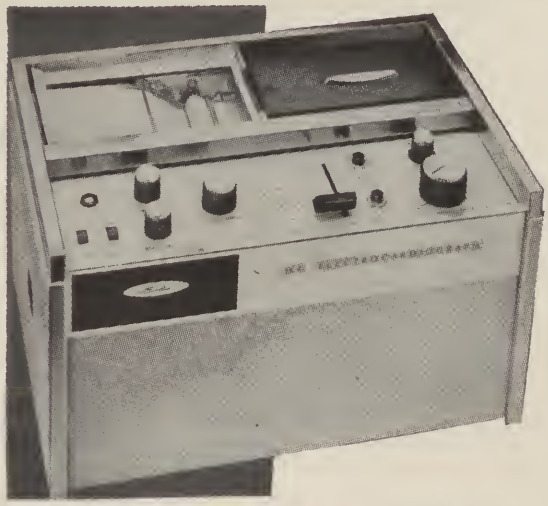
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against the usual gram-negative urinary pathogens

Why use five...where **one** will do?



In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)... and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



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Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa*.

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

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Maryland State Medical Journal
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December, 1966

AMA President-elect Will Address Faculty at Annual Meeting in April

Among the prominent, nationally known physicians who will address the Medical and Chirurgical Faculty of the State of Maryland at its 169th Annual Meeting in April is Milford O. Rouse, M.D., President-elect of the American Medical Association.

Dr. Rouse has been clinical professor of medicine at the University of Texas Southwestern Medical School since 1943, and is in private practice in Dallas. He was born in Jacksonville, Texas, and, as the son of Southern Baptist missionaries, he spent part of his boyhood in Cuba and Brazil. His desire to become a physician dates back to the age of five, when he was stricken with meningitis and a Brazilian doctor saved his life.

After receiving his BA and MA degrees from Baylor University, Dr. Rouse received his MD from its College of Medicine, and interned at Ft. Sam Houston Station Hospital. He has contributed more than a score of papers and medical articles to journals throughout the country.

In 1958-1959, Dr. Rouse was president of the Southern Medical Association, and he has also served as president of the Texas Medical Association. He is a diplomate of the American Board of Internal Medicine and of the subspecialty Board of Gastroenterology, and is a fellow of the American College of Physicians.



Milford O. Rouse, MD

Dr. Rouse was chosen President-elect of the AMA in June, 1966, and will take office as the Association's 122nd President in June, 1967. Previous to his election he served as speaker of the House of Delegates of the AMA, beginning in 1963, and prior to that he was vice-speaker of the House for four years.

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of the lecture presented by Dr. Rouse on Thursday on April 20, 1967, at the Alcazar in Baltimore.

Other Speakers

Other eminent physicians scheduled to present papers at the Annual Meeting in April are Michael E. DeBakey, MD, professor of surgery, Baylor University College of Medicine; James F. Holland, MD, chief of medicine, Roswell Park Memorial Institute; Walter L. Henry, Jr. MD, professor of medicine, Howard University; Edgar S. Gordon, MD, professor of medicine, University of Wisconsin Medical Center; John W. Walsh, MD, clinical professor of OB-GYN, Georgetown University School of Medicine; and Richard E. Palmer, MD, clinical professor of pathology, George Washington University School of Medicine.

James B. Brooks, MD, of Baltimore, is chairman of the Committee on Program and Arrangements for the Meeting.

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ETHICS SEMINAR FOR INTERNS AND RESIDENTS

A Summary

EDWIN J. HOLMAN, LLB
Director, Department of Medical Ethics
American Medical Association

The Ethics Seminar summarized here by Mr. Holman was held on Saturday, October 15, under the sponsorship of the Mediation Committee of the Medical and Chirurgical Faculty of the State of Maryland. At the morning session a panel of five physicians, representing as many different fields of medicine and surgery, pointed out problems in ethics which new doctors could expect to face upon entering practice. A round-table discussion in the afternoon dealt with the continuing questions of ethics which arise in the physician's relationship to the patient and to the community.

The Mediation Committee of the Medical and Chirurgical Faculty of Maryland is to be congratulated for having held this Seminar on Ethics for Interns and Residents. As J. S. Eastland, MD, said in moderating his panel, "As a baby is vulnerable at birth, so is the young physician on entering practice." The efforts of the medical society to reduce that vulnerability should be redoubled for the benefit of the public and the profession.

On Entering Practice

During the morning program, which consisted of a formal presentation of papers, several attempts were made to define ethics. One description of ethics not noted was that of Homer L. Pearson, MD, past chairman of the AMA's Judicial Council. He said that medical ethics distilled the best of the past to serve the needs of the present and provide for the advances that must be expected in the future. The panelists in the morning program seemed to base their discussions on just such a description.

Lewis P. Gundry, MD, speaking from the viewpoint of an internist, discussed the importance of hospital affiliations and the location of a physician's office in relation to his practice and to the hospitals with which he is affiliated. He described the proper forms of announcements to be used by physicians on entering practice and then spoke of the very practical matter of handling referrals. He emphasized that it is but a matter of courtesy to keep the physician who made the referral advised. He pointed out some of the difficulties that all physicians experience with referrals because patients may wish to change physicians for reasons best known to themselves. He discussed fees and emphasized that a physician should use common sense in establishing fees for his patients.

Dr. Gundry pointed out that physicians have to be tactful for the benefit of the individual patient and for the benefit of their colleagues in the medical profession. He suggested that physicians should review their practices regarding emergency care. He said that a physician is obligated to re-

spond to emergencies although, admittedly, the physician must use judgment in deciding what is an emergency. Occasionally, Dr. Gundry noted, a physician is called upon to see the patient of another physician during the latter's absence. He emphasized this is but a temporary arrangement and should be understood and treated as such.

Louis J. Kolodner, MD, representing the specialty of surgery, stressed the fact that ethics impose a self-discipline on the individual, a self-discipline that must be recognized and observed because of the idealism and nobility of the medical profession. He pointed out that the young physician wishes to be ethical in every respect. Many pressures, however, most of them economic, are exerted on all physicians and, as a result, the young man is subjected to many temptations.

Dr. Kolodner discussed the advantages and disadvantages of group practice and the absolute undesirability of fee-splitting. With regard to the latter subject, he said that economic pressures of many sorts make fee-splitting an ever present problem which must be vigorously attacked by physicians.

In connection with the increasing use of the emergency room by individuals, Dr. Kolodner stressed the point that the emergency room physician has an ethical and professional obligation to his colleagues to keep them adequately informed as to the nature of the emergency treatment and thus ensure the continuing care of a patient by his own physician.

Dr. Kolodner referred to some of the hazards a physician faces in everyday practice, particularly in regard to minor surgery and "compensation" practice. He said that the performance of minor surgery in a physician's office is probably not in the physician's best interest because of the danger of medical-legal involvements. He suggested that the physician use the emergency room or the out-patient department of a hospital for minor surgery. In connection with "compensation" practice, he said that the individual physician must always conduct himself in a manner which will reflect credit on the good name of the medical profession. Dr. Kolodner pointed out that all physicians have obligations not common to other men in connection with the organized activities of the medical profession. He urged all to participate actively in medical staff and medical society activities which are designed to benefit the public and to improve the medical profession.

Robert B. Goldstein, MD, also speaking on behalf of surgeons, emphasized certain key ethical concepts in medical practice, particularly those involving physician-physician relationships. He stated that it is most important to maintain close contact with a referring physician and to keep him advised of the course of treatment and the patient's condition. He stressed the importance of the specialist's recommending further referral with the advice of the attending physician. The ethical physician will not hesitate to use consultants, Dr. Goldstein said, and as a matter of fact the good physician will use consultants who are more expert because this is for the patient's benefit. He also pointed out that a physician's attendance at scientific meetings was important for his patient's benefit.

John M. Dennis, MD, representing radiology, stated that inasmuch as the patient pays for services, he deserves what he pays for. As a matter of fact, the patient deserves the best. Commenting on the desire of non-specialists to engage in specialized procedures on the assumption that they are helping their patients both scientifically and economically, Dr. Dennis pointed out that physicians who do this may be in error because they do not have the training the specialist has nor do they have his equipment. He knew of instances in which physicians had bought second-hand equipment for use in a specialty other than their own and this equipment, according to Dr. Dennis, was not always the best equipment, nor was it always properly calibrated or adjusted. Even in so-called routine procedures, he pointed out, the use of such equipment subjected both the physician and the patient to harm. Dr. Dennis also noted that the physician who engages in a specialty other than his own is frequently not prepared to cope with emergencies or extraordinary happenings, to his patient's detriment. He believes that the specialist engaging exclusively in his own particular practice best serves the patient and the attending physician.

Watson S. Kime, MD, representing pathology, suggested that the young man entering practice, although he wants to be ethical, is not always aware of what is ethical and what is not. He said that it is the obligation of physicians in practice to make certain that the young man entering practice

is educated in the spirit and intent of medical ethics. He stated that the practicing physician should impart his knowledge of this field to his colleagues and to his employees in order to develop a deep understanding and appreciation of ethical principles among all who assist in patient care.

Discussing laboratory procedures from a practical point of view, Dr. Kime pointed out that the physician can (a) have laboratory work done in his own office, (b) send a specimen to a laboratory, or (c) send the patient to the laboratory. He suggested that when the physician attempts to do laboratory procedures in his own office, time and equipment and knowledge are essential. He questioned whether the busy practitioner could afford the necessary equipment, devote the necessary time and develop the necessary knowledge to provide adequate service for the patient. He admitted that properly trained technicians could be used by the non-pathologist if a physician maintained his own laboratory, but implied that, even so, there would be enumerable difficulties for the nonpathologist.

In connection with laboratories themselves, Dr. Kime said that he had a basic rule, "If you send out, see it." He urged that every physician who plans to use the facilities of any laboratory visit and inspect the laboratory, its facilities, its procedures, and its personnel. He stressed the fact that a physician relying on a labortory is entitled to know the quality of the services offered and, furthermore, that a physician is obligated to his patient to use or to recommend laboratories that are competent in all respects to perform the services requested.

Finally, Dr. Kime cautioned physicians not to be taken in by some of the practices of some laboratories. He pointed out that some laboratories will provide office space for a physician who will permit the use of his name on the laboratory's letterhead. Others offer a physician all the laboratory work he needs for a small flat monthly sum, and still others offer physicians shares of corporative stock. Dr. Kime said that these proposals can be presented in a most attractive way and that occasionally a physician, without thinking, accepts one of these proposals. They are obviously not in the best interest of the physician or the patient. Many of them, he cautioned, amount to fee-splitting and solicitation of patronage, and none of them redounds to the credit of the medical profession.

Ethical, Legal and Moral Responsibilities

The afternoon session, in contrast to the formal morning session, featured a round table discussion. Panel members were William A. Pillsbury, MD, general practice secretary of the Medical and Chirurgical Faculty; Karl F. Mech, MD, surgeon and treasurer of the Faculty; W. Bradley King, MD, chief of pathology at Maryland General Hospital; and John King, legal counsel to the Faculty. William Y. Rial, MD, moderator, maintained a steady discussion of various ethical implications involved in actual medical practice.

Among the questions discussed from varying points of view were: What protection should medicine give the agitated patient, that is, the patient who may inflict harm on himself or another? What is the physician's ethical responsibility to an agitated individual who is in police custody or when law enforcement authorities seek medical assistance for the benefit of such an individual or his family? In discussion of this line of questions, the responsibilities of the physician as an attending physician, as a family physician, and as a member of the community, were explored. Mr. King pointed out that fear of litigation is not an acceptable excuse, from the ethical point of view, for failure to fulfill a professional obligation.

The subject of confidences arising from the physician-patient relationship provoked a considerable amount of discussion. When, if ever, it was asked, may a physician disclose confidences acquired during the physician-patient relationship? Reference was made to situations in which the physician has knowledge of an individual's personality, or character, or physical disabilities, of such nature that disclosure to a third party might prevent harm to the community at large. Another facet of the subject was examined as a result of the question, What would you do if a pregnant unmarried minor sought your professional service and insisted that you not divulge the nature of her condition to her parents? A lively and spirited discussion of this question indicated no unanimity of thinking among the members of the medical profession. Indeed, no conclusions were reached either on the general subject of divulging a patient's confidences, or on any of its diverse aspects.

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Another topic at the afternoon session was the opinion said to prevail among the public that physicians protect one another. Legal counsel for the Faculty suggested that there is some basis for the public's point of view and that the invocation of the doctrine of *res ipsa loquitur* stems from this practice.

In addition there was a discussion of the difference between privileged communications and confidential communications, and a discussion of the newly enacted Maryland statute which permits the application of the doctrine of privilege to psychiatric treatment conducted by a psychiatrist or a psychologist. The doctrine of privilege in Maryland does not extend to all physician-patient relationships.

There was also discussion of medical examiner cases in Maryland and of laboratory procedures in general. It was urged that a physician use the golden rule in connection with requests for laboratory procedures.

In general, the afternoon session touched upon the subjects of confidentiality, physician-patient relationships in general, physician-community relations, and physician-hospital relations. There was no mention of clinical investigation, the effect of automation, or the matter of relations between physicians and allied health professions and services.

Permeating the discussion were recognition of "benefit to the patient" and the application of the golden rule. Time after time, in one way or another, it was said that the physician should do unto others as he would have them do unto him.

What was not said at the Seminar was as important as what was said. The very fact that the conference was held indicates that medicine is trying to insure the observance of ethical principles and concepts. Even though not enough is being done or ever will be done, medicine should be proud of what it is doing, of its efforts to avoid evil and do good.

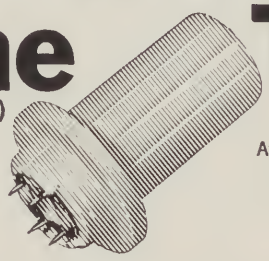
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Development of a New Carotid Artery Aneurysm in a Patient with a Previously Operated Ipsilateral Carotid Aneurysm

CHARLES M. HENDERSON, MD
Instructor in Neurological Surgery
University of Maryland School of Medicine

JOHN E. ADAMS, MD
Professor of Neurological Surgery
University of California School of Medicine

PAUL D. MEYER, MD
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A case of the development of a right carotid saccular aneurysm at a point one cm superior to a previous aneurysm is presented. Current theories of pathogenesis are presented and discussed. Once again, caution is urged regarding prognosis in patients who are operated upon for an angiographically single lesion.

In recent years the subject of cerebral arterial aneurysms has received much attention, and a great deal of information has been gathered pertaining to their natural history and operative treatment. It is generally accepted that multiple aneurysms occur in 15% of all patients in whom this diagnosis is established. To the best of our knowledge, however, the development of a new aneurysm on the same vessel at a point one cm from a previously operated lesion has never been reported in the literature and is the basis for this case report.

Case Report

This 34-year-old white male (J.E.A.), was first seen by one of us at the Oakland Naval Hospital in 1951 at the age of 19. The chief complaint at this time was severe right frontal headache. Past history revealed two previous bouts of subarachnoid hemorrhage, and physical examination revealed only a right third nerve palsy. Right carotid angiography was performed, and an aneurysm arising from the internal carotid artery at the junction of the posterior communicating artery was clearly demonstrated. At operation, silver clips were placed across the neck of the lesion, and the carotid was visualized up to its point of bifurcation into the anterior and middle cerebral arteries. There was no indication of another lesion on this vessel at this time, either by angiography or by direct visualization. His postoperative course was uneventful and, with the exception of an incomplete third nerve palsy and a mild left hemiparesis, he remained asymptomatic until April, 1964. At that time, he again developed right sided headache unassociated with nausea, vomiting, syncope, or paresis.

At the time of his admission to University Hospital in Baltimore, his general physical examination was within normal limits. Neurological examination revealed the patient to be fully conscious and oriented in all spheres. An incomplete third nerve palsy with associated diplopia was present on the right, and a mild hypesthesia and hypalgesia without motor deficit were demonstrable in the left arm and hand. The remainder of the

neurological examination was within normal limits.

Lumbar puncture revealed crystal clear fluid under normal pressure. A right carotid angiogram (see Figure) demonstrated the presence of a saccular aneurysm arising from the internal carotid artery at a point one cm superior to the site of the old lesion. On approach to the lesion through a right front-temporal craniotomy, it was noted that the anterior portion of the temporal lobe contained a large cyst which was probably due to hemorrhage into the area during a previous bout of bleeding. The infundibulum of the old aneurysm was identified and several clips could be seen across its neck. One cm superior to the old lesion, the new aneurysm was visualized and a Mayfield clip was placed across its fundus. The patient did well postoperatively with the exception of a mild cellulitis in the lower border of the wound which responded to conservative antibiotic therapy. Repeat bilateral carotid angiograms revealed good occlusion of both aneurysms and no further demonstrable lesions. When seen one year postoperatively, he was neurologically normal except for a persistent incomplete right third nerve palsy.

Discussion

The exact etiological factors in the development of saccular aneurysms still remain obscure, and relatively little new data has been forthcoming since the early works of Forbus[2] and Bremer.[1] Forbus felt that these lesions were due to a defect in the tunica media at the point of branching or junction of arteries, coupled with degenerative changes in the internal elastic membrane from continuous intravascular pressure. This theory could adequately explain the first lesion, but could hardly apply to the second since it did not occur in an area of bifurcation or branching along the parent vessel.

Bremer, and later Padget,[4] implicated persistent vessels of the embryonic capillary network as a possible factor in the pathogenesis of these lesions. These vessels, which may be blind arteries, vasa vasorum, or branches of meningeal vessels, have been shown to arise from main arteries, usually at right angles, and enter the muscularis as endothelial tubes surrounded by connective tissue or a thin muscular layer. If persistent, they may represent an area of structural weakness in the wall of the parent vessel which could expand to form an aneurysm under the influence of altered intravascular pressure. This concept is certainly attractive when one attempts to explain the second lesion especially in view of its locations, but more so in view of the fact that the hemodynamics in the parent vessel might well have been altered by the first operation.

Unfortunately, neither this case nor the one of Graf and Hamby[3] aid in clarifying this problem, but both should make us more cautious regarding prognosis in patients who have been successfully operated upon for a single demonstrable lesion.



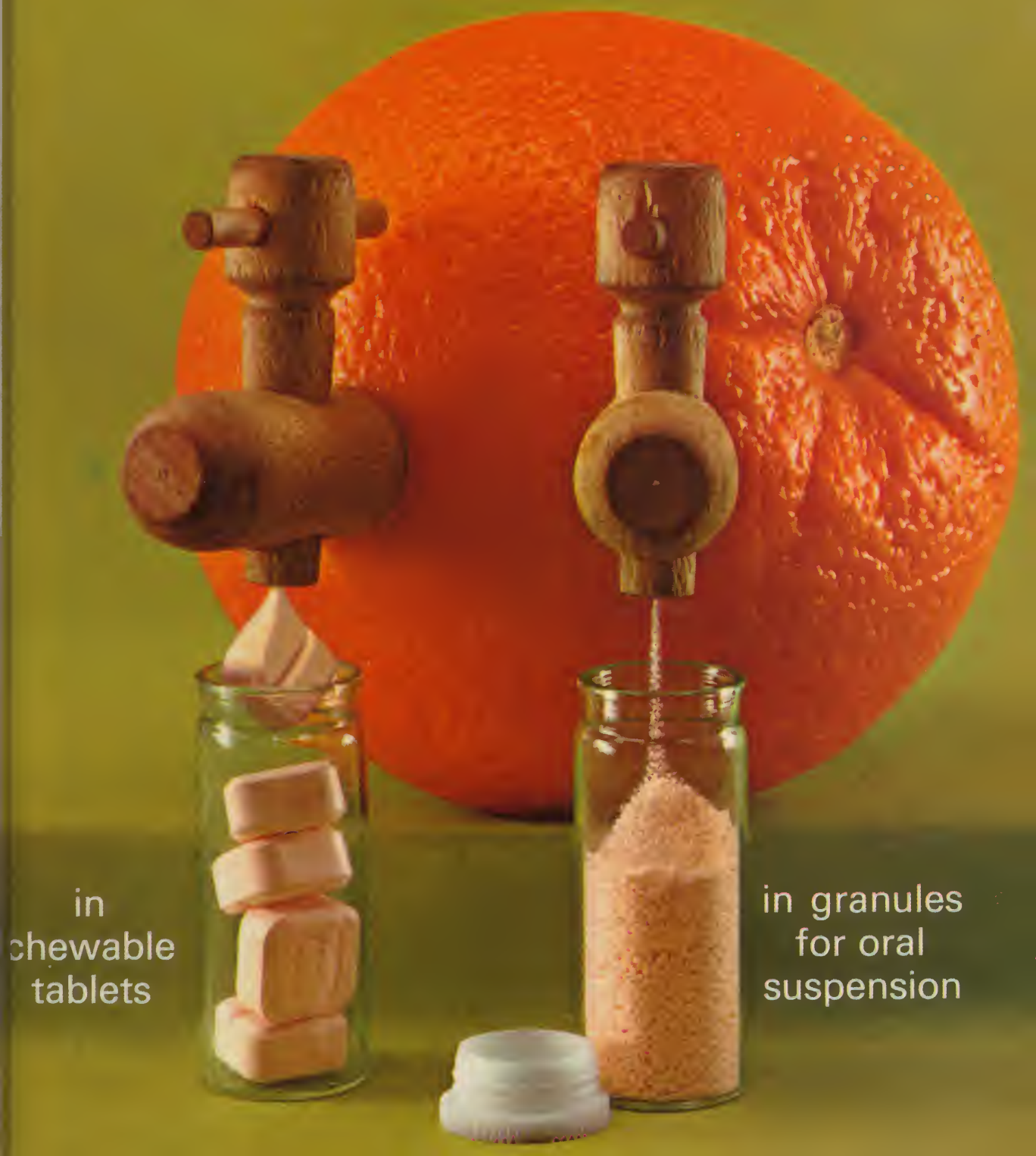
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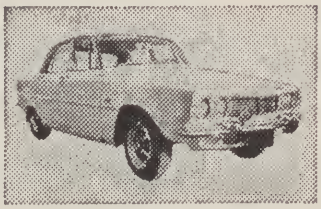
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MALIGNANT TUMORS OF THE PAROTID GLAND

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Assistant Professor, Department of Surgery,
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The clinical management of 38 patients with malignant tumors of the parotid gland is described. These tumors occur with equal frequency in both males and females. Pain in the region of the parotid tumor, facial nerve palsies, and palpable cervical nodes are clinical signs of the more malignant parotid tumors. The histologic patterns of various parotid tumors are discussed. Treatment policies, based on the clinical course and histologic pattern of the various types of parotid tumors, are defined.

The majority of parotid tumors are benign mixed tumors, or Warthin's tumors, which can be cured by parotidectomy with preservation of the seventh nerve. Approximately 25% of parotid tumors are malignant, however. These present a wide variation in histologic pattern which is reflected in a similar variation in their clinical behavior. Radical surgical excision of the parotid gland is associated with serious cosmetic and functional deformities secondary to excision of the facial nerve and portions of the mandible. It should therefore be undertaken only in the presence of firm indications associated with a reasonable chance of ultimate cure.

In an effort to delineate further the role of surgical excision in the management of malignant parotid tumors, the experience at The Johns Hopkins Hospital has been reviewed.[1] This series consisted of 38 patients, 17 males and 21 females. The patients ranged in age from 17 to 84 years, but the disease was most commonly encountered in the fourth and fifth decades. Patients with benign parotid tumors usually gave a history of a painless mass in the tail of the parotid gland which had been present for several years. Although both benign and malignant tumors can be present for a number of years without change in size, 40% of the patients with malignant tumors gave a history of a recent increase in the size of a previously quiescent mass.

Untreated benign tumors are rarely associated with any symptoms other than the presence of a mass. Benign parotid tumors usually present as a symmetrical, freely mobile, non-tender mass, which is characteristically present in the tail of the parotid gland. There are no associated physical findings.

Pain in the region of the parotid gland and partial paralysis of the musculature of the face are almost always indications of malignancy (in this series, 21% of the patients gave a history of pain in the region of the parotid gland and 7% detected paralysis of the facial nerve). Fixation of the mass and ulceration of the overlying skin are additional indications of malignancy. Facial nerve palsy (see Figure) and palpable cervical nodes are almost pathognomonic of malignancy.

Pathology

On the basis of histologic section, malignant parotid tumors can be divided into three general patterns:

(1) *Anaplastic carcinomas, squamous carcinomas, high grade muco-epidermoid carcinomas and glandular adenocarcinomas*—These tumors usually pursue a rapid clinical course associated with a high incidence of cervical lymph node metastasis and systemic metastasis.

(2) *Adenoid cystic carcinomas, acinic cell carcinomas, and malignant mixed tumors*—These tumors are characterized by a prolonged clinical course, with eventual death from local extension of the tumor; cervical lymph node metastases and distant metastases are usually only associated with extremely large primary tumors which have been present for a prolonged period of time.

(3) *Mid- and low-grade muco-epidermoid carcinomas*—These are relatively benign and remain confined to the parotid gland for long periods of time. Metastases to the cervical lymph nodes are extremely uncommon.

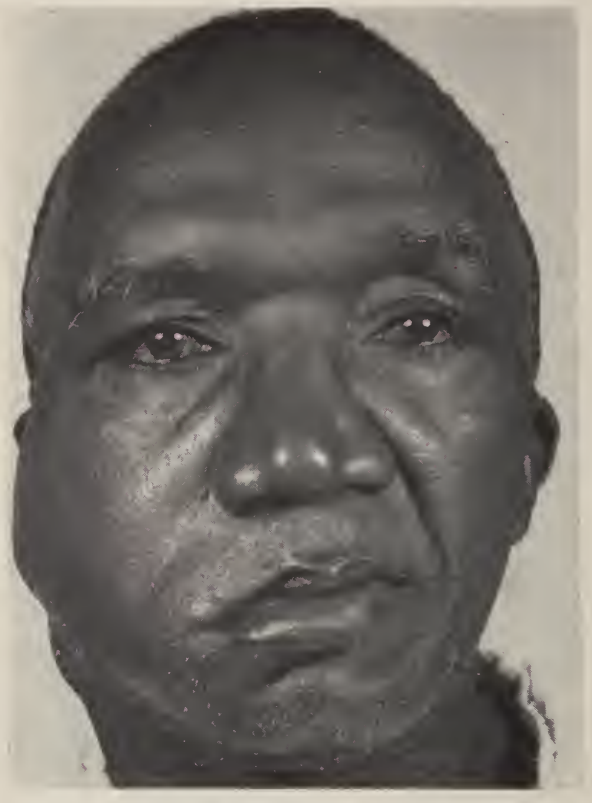
Treatment

All parotid tumors should be explored and an histologic diagnosis established, preferably by frozen section. If the diagnosis cannot be established on frozen section, definitive therapy should await permanent histologic sections.

Once a diagnosis of malignancy is established by histologic section, further therapy should be based on the clinical course and histologic pattern of the tumor. Radical surgical excision of the gland and facial nerve with an associated radical neck dissection is indicated in selected cases. An appreciable number of patients can be cured, however, by an operation, which is associated with considerably less morbidity.

The histologic diagnosis of high grade muco-epidermoid, anaplastic, and squamous carcinomas appears to be a firm indication for a radical parotidectomy with excision of the facial nerve, excision of a portion of the mandible if necessary and, in continuity, radical neck dissection. A 37.5% five-year survival was accomplished in this series of patients by such an operative procedure. This has also been the experience at the Mayo Clinic as reported by Freeman et al.[2]

Adenocarcinomas and malignant mixed tumors present more difficult decisions as to optimal management. As previously noted, these tumors—particularly the adenoid cystic lesions—usually exhibit aggressive local growth tendencies. Metastasis to the cervical lymph nodes and distant metastases are, as a rule, associated with large primary tumors which are inoperable on the basis of local extension. An operation should be designed to obtain a wide local margin around the tumor and should include any structures within 2 -3 cm of it. In the series of cases in question, a parotidectomy with preservation of the facial



Malignant parotid tumor with associated facial nerve palsy.

nerve was performed in ten patients with relatively small tumors. A 60% five-year survival rate was obtained. A radical parotidectomy with excision of the facial nerve and also partial mandibulectomy, was performed in six additional patients with a 16% five-year survival rate. Ultimate survival appears to be primarily dependent upon the size of the tumor at the time of initial therapy. In the presence of a large primary tumor, an aggressive surgical approach seems indicated particularly with the adenoid cystic carcinomas. A

conservative parotidectomy with preservation of at least portions of the facial nerve seems reasonable in the management of the smaller tumors.

Mid- and low-grade muco-epidermoid carcinomas are managed by a parotidectomy without sacrifice of the facial nerve. If the nerve or one of its branches is adherent to the tumor, that portion of the nerve should be excised with the tumor. A radical neck dissection is almost never indicated. A 100% five-year survival rate was obtained in nine patients in this series by such an operative procedure. Three patients with mid- or low-grade muco-epidermoid carcinomas were subjected to a radical parotidectomy with excision of the facial nerve and an associated radical neck dissection. Two of these patients survived and neither of these patients had evidence of cervical lymph node metastases on histologic section. The only death in the mid- and low-grade muco-epidermoid group occurred in a patient who was subjected to a radical parotidectomy and radical neck dissection, but succumbed to liver metastasis.

If it is necessary to sacrifice the facial nerve, immediate reconstruction by nerve graft is indicated.[4] For this reason, the greater auricular nerve is preserved during the operative procedure in the event that a subsequent graft is necessary.

The clinical management outlined above is designed to subject only those patients with certain types of malignant parotid tumors to extremely radical operative procedures. It has been shown in this series, and in others,[1, 2, 3] that excellent survival rates can be obtained with certain types of malignant parotid tumors by operative procedures which do not result in severe cosmetic and functional deformities associated with excision of the facial nerve or a partial mandibulectomy.

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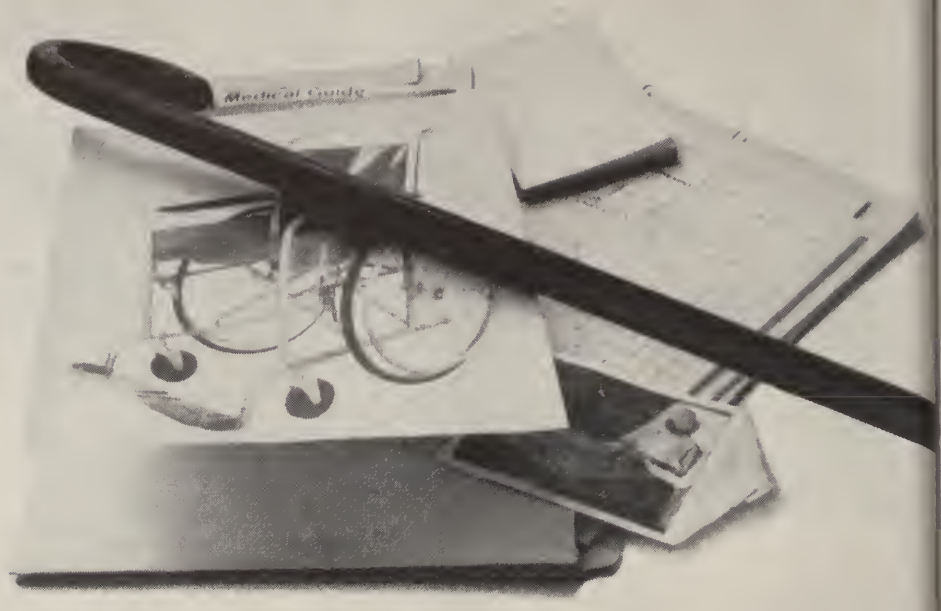
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PRECEPTORSHIPS AND THE PRACTICE OF MEDICINE

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Although preceptorships in general practice have been sponsored by medical schools for a number of years, there is little evidence that they have favorably affected medical students' interest in a career in general practice. Present influences on career choice are examined and a new program is suggested which might provide a more meaningful and rewarding experience for medical students, and relate directly to the future practice of medicine.

Concern for the shortage of general practitioners in Maryland has resulted in the formation of a special Governor's committee, some legislative hearings and, last year, even legislative action. In an attempt to remedy this shortage, the Governor's Commission to Study the Shortage of General Practitioners in the State of Maryland, and a legislative committee this year, have discussed the use of medical student preceptorships as a means of interesting medical students in a career in general practice. Implicit in the recommendation for the establishment of a preceptorship program in a medical school, particularly the University of Maryland School of Medicine, are two assumptions: (1) career choice of medical students can be influenced by the faculty or by elective and required undergraduate programs; and (2) experience in an elective or required preceptorship with a general practitioner will favorably influence career choice of medical students toward general practice. This paper will examine these assumptions and suggests an approach which might interest medical students in a career in family practice.

There is ample evidence that expressed career choice changes as the student proceeds through medical school and that far more medical students now express a career choice for specialty practice than did only a few years ago. On a number of occasions, the Association of American Medical Colleges has collected data on career choices from students at the time of graduation, or soon after graduation. The results of their studies indicate a rise in career choice for specialty practice from 63% in 1950 to 78% in 1961, and a decrease in career choice for general or family practice from 33% in 1950 to 18% in 1961.[1]

In the academic year 1962-1963, each student at our medical school was requested to provide information about his career interest. The career choices of the 352 students are shown in the Table. It will be noted that a large percentage of students begin medical school with an expressed career choice for some specialty or for a combination involving a specialty, and that the percentage increases over the four-year period. The

proportion of students choosing general practice, on the other hand, declines during the four years of medical school, and it is the specialty practice, research and teaching combination that absorbs the difference.

A decision for specialty practice is frequently made after graduation from medical school. In a study of trends in medical practice among medical school graduates from 1915 to 1950, Weiskotten reported that about 35% of the physicians who ultimately practiced a specialty decided upon this specialty in medical college and an additional 35% during the internship period.[2] About 25% made the decision during military service, during residency, or after a period of practice. The most recent survey of career choice of interns during the year 1964-1965, pointed out that 13% of 5,200 interns indicated reasonably definite intention to enter the field of general practice. Six years earlier, a survey of 2,600 interns indicated that 21% intended to enter general practice.[3]

Coker and others working at the University of North Carolina have inquired into factors that influence physicians in their choice of particular specialties or types of practice, and have made a number of reports.[4, 5, 6] Information was obtained from over 2,600 medical students at eight schools in a national sample, and the reports of these investigations clearly indicate that faculty members exert an influence on career choice.[4] One report in this series concerned specialization and general practice.[5] Among other differences, it was found that those medical students choosing general practice were more likely to be older, come from smaller towns, and have less financial resources.

The authors suggested that scholarships and loan funds would increase the number of physicians going into general practice. (In 1965 the Maryland Legislature approved funds for scholarships to medical students willing to commit themselves to a career in general practice in the State.)

Faculty Influence

The North Carolina studies of faculty influence on career choice of medical students clearly indicates such influence. Although these studies did not focus primarily on elective opportunities or summer fellowship work, it does seem likely that such experience contributes to this effect. Traineeships, fellowships, and other part-time work, supported largely from training grants or other restricted funds, are available for medical students in almost all medical specialties. Being aware of the lack of such opportunities in preventive medicine at the University of Maryland School of Medicine, and aware of Coker's report of the lack of influence of public health faculty members on career choice of medical students,[4] the Department of Preventive Medicine developed, some years ago, an undergraduate training program in epidemiology. This summer apprenticeship pro-

Career Choices of Students at University of Maryland School of Medicine

(1962-1963)

	All Students (N=352)	Freshmen (N=103)	Sophomores (N=99)	Juniors (N=78)	Seniors (N=72)
General Practice	24.1%	28.2%	29.3%	17.9%	18.1%
Specialty Practice	34.7	32.0	38.4	34.6	33.3
Specialty Practice/Research and Teaching	34.7	31.1	26.3	41.0	44.4
Research and Teaching	2.8	2.9	4.0	2.6	1.4
Other	1.7	1.9	1.0	2.6	1.4
No Response	2.0	3.9	1.0	1.3	1.4
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%

gram has been active for the last five years and has developed to the point where we can accept less than half the students who apply. Since this program has been available only a short period of time, no statement can be made about ultimate career choice for students who have participated in it, but we feel sure that a number of these current and former Fellows will make a career choice for preventive medicine, particularly academic preventive medicine.

Preceptorships

Although there is some information about influence of faculty and curricular programs on medical student career interest, the situation is less clear with respect to the influence of preceptorships on career choice for general practice. Preceptorships on either a required or an elective basis have been available at a number of medical schools for many years. A recent summary in the *Journal of the American Medical Association* indicated that 19 schools had established preceptorships in 1950.[7] By 1955, 25 schools offered preceptorships and almost 1,500 students participated on either a required or elective basis. In the year 1963-1964, 36 of the 87 medical schools reported some kind of preceptorship program. The program was required in 10 of the schools and elective in the remaining 26, and 979 students participated in the 26 programs during that year. Despite the increased number of available preceptorships, the total participating students has decreased over the 10-year period.

The opinions of faculty members on the value of such preceptorships vary significantly. At the First Institute on Clinical Teaching, sponsored by the Association of American Medical Colleges, opinions were obtained from deans and department heads on the value of preceptorships.[8] A preceptorship program was regarded as either harmful or of little or no value by 39% of 81 deans, and 37% of 391 department heads held a similar opinion. Sixty percent of the deans and 53% of the department heads thought that the preceptorship had some or much value. As might be expected, the opinions of the faculty members varied depending on whether their school did or did not have such a program. Forty-two percent of the participants at this conference who were from schools without a preceptorship program, felt that such a program was harmful (12%) or of little or no value (30%).

The Fifth Teaching Institute of the Association of American Medical Colleges, concerned with the ecology of the medical student, also touched on family care programs and preceptorships.[9] Excerpts from a number of letters published in the Institute report included comments that varied from "(the preceptorship program) is the most important single educational unit of their undergraduate years," to "until it has been demonstrated that extramural preceptorships can accomplish maintenance of high standards in teaching, I believe that any school that uses them must be considered to be providing its students with second-rate teaching, and that extramural preceptorships presently in existence should be abolished or reorganized."

Although the influence of preceptorship programs on career choice of medical students has not been completely evaluated, some information is available on the University of Wisconsin preceptorship program initiated over 25 years ago.[7] An evaluation of this program through the use of a questionnaire was completed in 1956 and indicated that the preceptorship program at Wisconsin had not influenced students to enter general practice.

Discussion

There seems to be little value, then, in replicating at our school, preceptorship programs tried at other schools. We might, however, consider the development of new programs or educational experiences which could influence the students' career choice for the practice of medicine in the future. Medical student education today should be considered in the light of the future because the average medical student has two more years of school, a year of internship, and a few additional years of postgraduate training. Most of the students will then spend two years in the armed services before starting their practice.

Predictions about the future practice of medicine, on which to base the development of a student program today, are clearly beset with difficulties. Many changes have occurred and are occurring in the complex social area of health care

in this country. In the last few years, hundreds of papers have been published in various medical journals concerned with changes and problems in health care. A number of these papers have focused on the future of general practice and some have been concerned with problems of organization of medical care, financing medical care, facilities and manpower, continuing education of physicians, administration and coordination of health services, and so forth. Discussion and studies in any of these areas can result in judgments and programs affecting the practice of medicine today and in the future. Opinions and suggestions concerning many of these problem areas vary just as widely as the comments quoted above about preceptorships. The development now of a special training program geared to the future practice of medicine would, of necessity, result from judgments based on incomplete information.

Probably the most important judgment concerns the personal physician: will he be needed and should we plan for his recruitment and training? In my opinion there is now, and will continue to be in the future, a significant portion of the population which wants to have, and should be provided with, the services of a personal physician, a physician who will provide continuity and coordination of medical care services for the patient and other members of his family. This portion of the population can be defined on the basis of age, the presence of certain illnesses or their probability of development, and other characteristics. We therefore need to plan for the recruitment and training of the future family-physician specialist.

We need to consider what programs or opportunities should be developed for medical students in order to acquaint them with, and interest them in, such a career. Clearly, the students should have an opportunity to observe, participate in, and learn from, a program of modern family-practice, and they should have an experience which is intellectually stimulating, exciting, and rewarding. I believe such a program can be developed with the efforts of medical school faculty and others. This program could have two components: (1) a family-practice clinic or service as an integral part of the medical school center and (2) an extramural program related to the practices of selected private practitioners.

The family-practice clinic at the medical school would be developed to provide ambulatory medical care to a few thousand families and it could be located either at or near the medical center. The families included in this program would be selected from patients who now seek their primary care from the outpatient department clinics and emergency room at the medical center—the financially indigent and the medically indigent. The changes in the Maryland Medical Care Program for these patients and the availability of special funds from the Childrens Bureau of the Public Health Service would facilitate the development of this special clinic. The program of health care made available would be the best family medicine that can be developed and would include continuity and coordination of care, health education, clinical preventive medicine and other services. It would be a place where the student could see practiced what many teachers recommend in terms of good medical care. It would be a more ideal setting for learning ambulatory medical care than the busy outpatient department specialty clinics where most medical students are now assigned. These clinics usually treat patients for episodes of illness with little evidence, to the student, of continuity and coordination of care.

I am confident that faculty members, with the assistance of other practitioners, can develop such a clinic, and that this experience for medical students would be stimulating, interesting, and rewarding. This clinic would also provide an opportunity to gather data from a specific number of families on prevalence of diseases, association of diseases in certain groups, the effects of different approaches and techniques in health care, and administration of health services to groups of patients; it would be, in other words, a clinic for research studies in medical care. Hopefully, the practicing physicians assisting the medical school in the development of this clinic would be those whose own private practices would later serve as bases for the extramural program. There are many advantages to this approach. The practicing physician's knowledge and experience from practice would be useful in determining the scope of services to be provided these patients, the staffing of the clinic, and the use of auxiliary

personnel. We would learn jointly about the use of multiphasic screening tests and other techniques of health care, as well as experimental procedures in the provision of medical care services. The practicing physicians would become more familiar with current teaching programs at the school, particularly as they affect this family-medicine clinic. They would also learn about teaching techniques and realistic learning objectives for the students' experience in this clinic and thereby become more effective teachers.

The practicing physicians would also participate with us in the development of a record-keeping system for the family-practice clinic, a system that could be adapted to the physician's own practice for medical care research studies in community practice. The development of community family-practice opportunities for the medical students would take place after the family-practice clinic at the medical center had provided ample opportunity for the identification of appropriate objectives of service, teaching and research which could be transposed to the physicians' private practice.

These plans would certainly result in changes in the physician's practice, not only because of the development of learning opportunities for students in community medicine, but also because of changes resulting from experience in the family-practice service at the medical center. Changes, in the physician's practice, particularly record-keeping, would let the practice serve as a community laboratory for comparative studies in medical care. To a certain extent the anticipated changes in the physician's private practice which would make it a more ideal setting for an educational experience in community medical care, will result in additional expenses. Since these changes also would be of benefit in the broad research area of medical care, it seems likely that most, if not all, additional expenses could be funded with monies obtained for research and demonstration purposes.

This extramural counterpart of the family-practice clinic would give the student an opportunity to be exposed to a community practice within an environment of active inquiry into medical problems and, in so doing, would certainly enhance the educational value of the program. The extramural phase of the program would also include private patients of a different social class from those identified with the University Hospital practice clinic and thus would be more representative of the "average" or future practice of the medical students.

The family-practice clinic could also be used as a residency training area for the future personal physician and for other future specialists. This post-graduate training activity would complement and enhance the undergraduate program. It could also assist in recruiting physicians for this specialty, provided adequate training stipends were available. Grant funds presently support graduate training in a number of clinical specialties and sub-specialties. These funds are made available to increase the number of clinicians, clinical investigators, and teachers in specific specialties, particularly those where there is recognized and national need for more trained individuals. The stipends available for some of these fellowships are quite handsome in comparison with residency stipends of other clinical programs and serve as an incentive for training in a particular specialty. For a number of years the University Hospital has had an approved training program in Physical Medicine and Rehabilitation which is supported by funds from the Vocational Rehabilitation Administration. The fellowship stipend of the "residents" supported by this grant has varied from $6,500 to $8,900 a year. Residents in General Preventive Medicine or Fellows in areas of public health and epidemiology have a fellowship stipend beginning at $6,000, plus a dependency allowance. The most recent data on appointments to approved residency programs indicate that only 58% of available positions in general preventive medicine are now filled, and that only 46% of residencies in physical medicine are now filled.[10] This proportion of filled appointments is similar to that of approved general practice residencies, only 49% of which are filled. Many individuals involved in residency training in both preventive medicine and physical medicine feel that a post-graduate program with the stipend levels available, particularly when associated with an effective and meaningful undergraduate program in these same areas, will do much to improve the shortage of trained individuals in these areas, and, within a short period of time, to increase



The "Socio-geographic" mystery

hy is one man's gastric ulcer nother man's duodenal?



Geographic variation in the *incidence* of peptic ulcer is a familiar fact. But the proclivity of certain *kinds* of ulcer for certain geographic areas is a recently recognized phenomenon.[1,2]

For example, in one particular Norwegian fishing village there is a tendency for patients to develop a gastric ulcer; anywhere else in Norway, ulcers are usually duodenal. Peruvians high in the Andes have more gastric ulcers than their compatriots in the lowlands. Why? Nobody knows.

Social variations, too. Even in the same aphic areas there are interesting variations. An Englishman's ulcer depends h social standing—professional men suffer with duodenal ulcers, while ngmen have more of the gastric variety. In southern India the pattern is ed. Here, duodenal ulcers are common among laborers and agricultural rs and rare among the upper classes.

restigators are exploring every possible theoretical avenue in their search e cause of peptic ulcer. Of all the factors implicated in ulcerogenesis, ne that is generally acknowledged to be of primary importance is hyper- ion of gastric acid.[3-8] Or, as one author states it: "The medical management ptic ulcer pharmacologically is, in the final analysis, concerned largely the effective inhibition of peptic activity."[3]

binul (glycopyrrolate) provides potent, rapid, specific antisecretory action med by gastric analyses and x-ray evidence of clinical effectiveness.[3,7,9-12] ves pain with "impressive" promptness.[8] Quickly alleviates acute discomfort, ffectively counteracts gnawing pain, preprandial midepigastric pain, ing and other ulcer symptoms.[7] Suppression of nocturnal pain is "out- ing."[13] Maximally effective doses may be given with minimal side ons, and the incidence of unwanted anticholinergic effects is negligible.[3,7-14]

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Dosage: Dosage should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet 3 times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*
Supply: Robinul (glycopyrrolate 1 mg.); Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: May be habit-forming.) In bottles of 100 and 500 scored tablets.
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the proportion of residencies filled with well qualified trainees and Fellows. I feel that similar statements could be made about the future personal physician and his training.

Conclusions

This paper has reviewed briefly the changes in career choice of medical students, and the influence of faculty members and preceptorships on that choice. Clearly the number of students selecting a career in general practice has decreased over the years and preceptorships, as presently constituted, appear to be decreasing in popularity. Evidence has not yet been provided that they influence a career choice for general practice.

This paper outlines a proposal, for consideration and discussion, for the development of a family-practice clinic and related extramural private practice resources. The purpose of such a program is to provide students with opportunities for learning in the area of family and community medicine. This proposal is not complete and many more details need to be worked out. I am confident, however, that there are practicing physicians who would be willing to work with the faculty in the development and implementation of such a program and who would be willing to use their own private practices in this endeavor.

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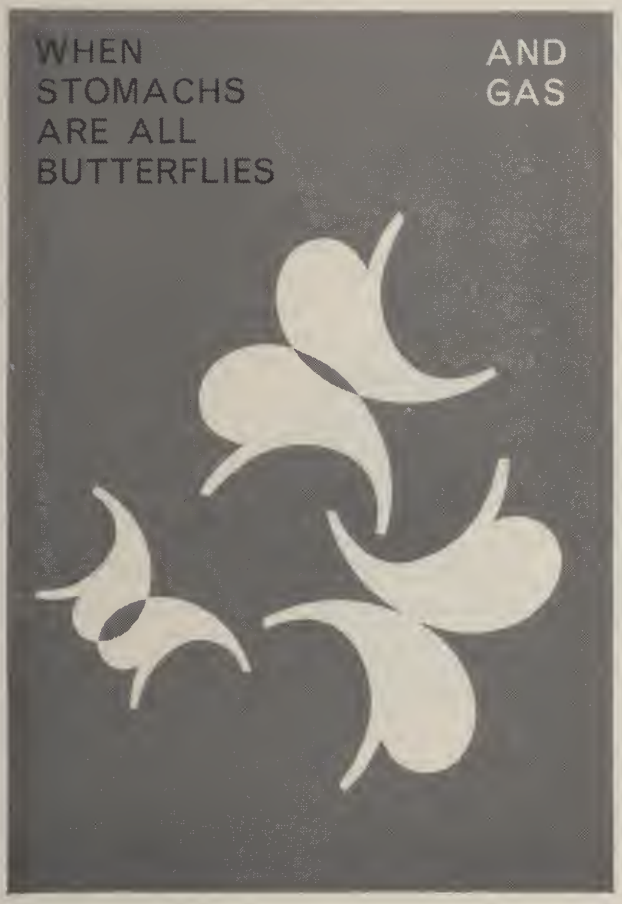
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CHANGING PATTERNS OF PSYCHIATRIC CARE IN MARYLAND

KURT GORWITZ, ScD
Director of Mental Health Statistics
State of Maryland Department of Mental Hygiene

Most of the improvements in the care of Maryland's mentally ill have occurred since the exposure of "Maryland's Shame" in a series of articles, under that title, published in 1949. Although statistics per se appear to justify feelings of satisfaction and complacency with regard to accomplishments in this field during the past 17 years, a closer look reveals many serious deficiencies. Meanwhile, responsibility for care of the mentally ill, once conceived as that of local municipalities, is evolving, in part, from the state to the federal government. Past improvements, present problems and anticipated developments in the future are enumerated here.

In most states the care of the mentally ill was the legal responsibility of the county or local municipality until the last decade of the 19th century. They generally met this requirement by confining their mentally ill in local jails and almshouses. The concept of state responsibility met with widespread scorn and derision from those who considered this a problem primarily of local concern. The concept of federal financial support for state mental health programs was incorporated in a bill adopted by Congress in 1854. In a message accompanying his veto, President Pierce stated that the alleviation of social problems was not a proper concern of the federal government. Federal support for mental health programs remained minimal until the passage of the National Mental Health Act in 1946.

In Maryland, the Allegany County-operated Sylvan Retreat in Cumberland, which dates back to this period, is still in use as a facility for the mentally ill. In its basement one can see the dreary dungeons in which "unruly patients" were kept. It requires little imagination to picture how these patients were maintained and the effects of this confinement.

One of the leading exponents of improved care for the mentally ill through the establishment and improvement of state-operated hospitals was Dorothea Dix. She came to Maryland in 1852 and addressed a joint session of the Legislature. Her carefully documented presentation led to the establishment of the Spring Grove State Hospital at its present Catonsville site. It had previously been called The Maryland Hospital and was located on the present grounds of the Johns Hopkins Hospital. Care of Maryland's mentally ill continued to be primarily a county responsibility, however, until the establishment of the State Commission of Lunacy in 1886. The present system of State hospitals dates from this point in time. The Com-

Presented at the American Psychiatric Association Regional Research Conference on Psychiatric Epidemiology and Mental Health Planning, Baltimore, April 21, 1966.

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mission, from its inception, had supervisory powers over all public, corporate and private institutions in which insane persons were kept.[1] As part of its responsibility, the Commission developed a centralized patient-reporting system for all of these facilities which, 75 years later, was one of the factors related to the establishment of the Maryland Psychiatric Case Register.

This Commission (and the Board of Mental Hygiene which succeeded it) published annual reports from its inception until the establishment of the Department of Mental Hygiene in 1950. The reports indicate a program gradually improving because of the application of new psychiatric treatment concepts and modalities. This picture was fortified by a number of local grand jury reports which, although usually brief and superficial, were almost unanimously favorable. For example, it was reported after Worl War II that as many as 70% of admitted patients could ultimately be released as improved or cured. Based on 2,000 admissions annually, this figure would indicate that 600 or more patients per year became chronic while hospitalized.

In 1948 charges of serious deficiencies in the State mental hospital program came to the attention of the *Baltimore Evening Sun*. It assigned a reporter named Howard M. Norton to ascertain the facts. His report was published in a series of articles from January 9-19, 1949, under the headline "The Worst Story Ever Told By The Sunpapers." It became subsequently known as "Maryland's Shame."

The articles showed that only a small proportion of the patient population received available psychiatric services. Many patients were hospitalized for several years before being seen by a psychiatrist. Most received only custodial services, usually in overcrowded buildings of unsafe construction. Each of the hospitals was seriously understaffed and therefore sought to control disturbed patients by placing them in a variety of mechanical restraints. This practice had been discontinued as unnecessary and harmful to the patient in some English hospitals as far back as 1839.[2] Physical mistreatment of patients by the staff and by other patients was common. Mr. Norton charged that the hospitals were breeding chronic insanity faster than they cured it and were declining steadily toward the level of the 19th Century insane asylum where "the inmates raved and screamed their lives away out of sight and hearing of society." He pointed out that the many favorable reports published earlier were based on cursory examination by disinterested and uninformed citizens.

Maryland's Shame had its counterpart in many other states. It represented the end product of 20 or more years of accumulated neglect. Beginning with the depression in 1929, operating funds of mental hospitals were reduced to a minimum subsistence level. In the early days of the New Deal, $12 million in federal funds were available through the Public Works Administration, on a 50-50 matching basis, for mental hospital construction. Four-fifths of this money went to three states. Maryland, in company with most other states, did not participate because of its unwillingness or inability to provide the required matching funds. During World War II widespread personnel shortages caused further deterioration. The employment of conscientious objectors was not sufficient to halt this decline. Finally, slowly rising State support in the postwar period failed to keep pace with the increasing patient population.

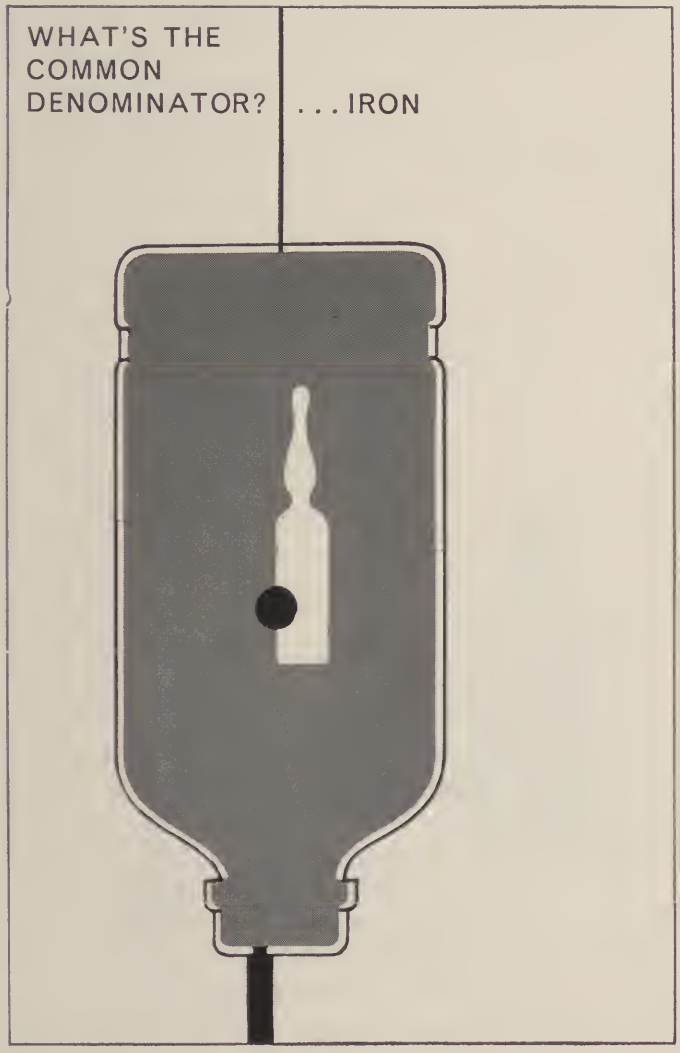
Seventeen years have passed since Maryland's Shame roused officials and a concerned public to action. A great many changes have occurred during this time, some of them measurable. Among the most important of these are the following:

1. In 1949 statistics were limited to basic information on the flow of patients into, and out of, State-operated hospitals. Since 1961 the Maryland Psychiatric Case Register has been providing unique research data based on the longitudinally linked record of services received by 60,000 Maryland residents in more than 130 public and private inpatient and outpatient facilities.

2. Between 1949 and 1959 the State's expenditures for the operation of its mental hospitals tripled. They have doubled in the last seven years. The average expenditure per patient per day is now nearly five times as large as in 1949.

3. Until 1949 Maryland spent an average of $350,000 per year for capital construction in its mental hospitals. In the last 16 years, it has annually spent in excess of $2,500,000. The availability of additional facilities, together with a decline in the size of the patient population since 1955, reduced overcrowding in State hospitals

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from an estimated 50% in 1949 to 15% in 1965.

4. The number of professional and non-professional employees and their ratio to patients have greatly increased in the State hospitals. In 1949, there were 12 registered nurses, or one per 750 patients; now there are 140, or one for every 60 patients. The ratio of psychiatrists to patients has tripled in the last 10 years alone. For many patients, the attendant is the most frequent and important contact with the hospital staff. The ratio of attendants to patients has doubled since 1955. Similar changes have occurred in other categories.

5. The average patient population, which had increased steadily until it reached its peak in 1955, has now decreased almost to the level of 1949—even though admissions quadrupled from 2,000 to more than 8,000 between 1949 and 1965.

6. In 1949 it was reported that up to 70% of newly admitted patients could ultimately be released as improved or cured. Latest register data indicate that in excess of 90% of all admissions are released within two years. Among an increasing number of specific age and diagnostic cohorts, almost all are released within one year. For example, among psychotic patients aged 35-44, 54% were released within 3 months, 85% within 12 months, and 91% within 18 months. Among patients in this age group with psychoneurotic and personality disorders, 93% were released within one year.

7. Voluntary admissions, virtually non-existent in 1949, now account for 40% of all patients entering State hospitals. The court-committed, who a few years ago represented one-fifth of all admissions, now account for less than one out of every nine.

8. In 1949 the State mental hospital was the major treatment facility. Although statistics are not available for 1949 on the number under care in private or general hospitals, in outpatient facilities and in private practice, it is believed to have been a small proportion of the total patient load. By comparison, latest available Register data (for 1964) indicate that State mental hospitals now account for less than one-third of all admissions. The remainder include 51% to private hospitals, 7% to general hospitals, and 2% each to university-connected hospitals and to the VA hospital at Perry Point. The other 5% went to outpatient facilities. The year 1964 was actually the first in which a majority of reported psychiatric admissions were to community facilities. Patients seen in private psychiatric practice are not now reported to the Register and their number is therefore not known.

9. The State hospital's isolation from the community, a prominent feature in the days of Maryland's Shame, is increasingly becoming a fact of the past. The State has established or expanded its specialized programs in such areas as child psychiatry, forensic psychiatry, alcoholism, drug addiction and geriatrics. Programs in private hospitals, general hospitals and outpatient facilities, although in existence for many years, have increased in number, scope and variety. At the same time, new program concepts, such as day care centers, sheltered workshops and half-way houses, are becoming a reality. Comprehensive Community Mental Health Centers will soon be in existence in the Baltimore area and in other sections of Maryland. This plethora of facilities and services is changing the State hospital into one of the links in a chain designed to provide the mentally ill with a continuum of care. In addition to this, and related to it, there is growing recognition that we cannot be content with the treatment of the individual acutely ill patient: Our responsibility extends to intervention in the social situation in order to improve and promote mental health. If we ignore this, we will be eternally trying to go down an escalator which inexorably is going up.

10. Maryland, for the first time, has a comprehensive plan for meeting the future mental health needs of its population.

These basic facts are, I am sure, well-known. They readily lend themselves to a feeling of accomplishment and self-satisfaction. Lest we lapse into this state of euphoria, however, let us consider them in somewhat more detail:

1. Maryland's rising expenditures have barely kept pace with the general increase reported from all sections of the nation. Many of the more progressive states, such as Kansas, spend substantially more per patient per day than Maryland. Proportionally, expenditures at the Perry Point VA Hospital have continued to be twice as large as comparable figures for State-operated hospitals. Due to inflation, the 60¢ the state now spends to feed a patient per day is actually less than the

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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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46¢ spent in 1949. The expenditure for research and statistics by the state in 1966 accounts for less than one % of the Department's operating budget. Both continue to be financed primarily with federal funds.

2. It should be recognized that average figures can be very deceptive since they offer no indication as to the variation within the group. Where major variations exist, changes in the average may reflect internal changes in the group's composition. The Mental Hygiene Department's budget offers an example of this. One factor responsible for its increasing expenditures has been the four-fold increase in admissions and the six-fold increase in releases. This has produced a gradual rise in the number of beds occupied by short-term patients and a concomitant decline in the beds occupied by the chronically ill. In 1949 two-thirds of all beds were occupied by patients hospitalized continuously for five years or more; this proportion is now approximately one-half. In 1949 those hospitalized continuously for less than one year occupied less than 15% of hospital beds; they now occupy one-fourth. While accurate cost figures are not available, it is estimated that the cost per patient per day for the chronic versus the acutely ill is in the ratio of one to three or four. Another factor which also tends to distort longitudinal trends is the fact that the cost of the Department's pre- and post-hospital services and the operation of its reimbursements program, although not related to inpatient care, are now nevertheless included in hospital budget statistics.

3. The reduction in overcrowding from 50% to 15% between 1949 and 1965 has been accomplished mainly through an expenditure in excess of $40 million for hospital construction. Many of these newer buildings, however, exhibit the same features as older buildings—open wards with sleeping areas for 20 or more patients, together with bathroom facilities offering a minimum of personal privacy. It should be clear that this is not considered conducive to patient recovery and is at variance with the concept of a patient as an individual having certain basic, personal rights.

4. Statistics on employee-patient ratios do not necessarily present an accurate picture since they do not indicate the employee's function in the hospital structure. For example, 10 of the Department's 119 psychiatrists serve in its headquarters. An additional 23 in the hospitals have a primarily administrative responsibility such as superintendent, clinical director and director of education. Further, eight are primarily engaged in outpatient services. One-third are therefore not engaged in hospital patient treatment and only the remaining 78 should be counted in a psychiatrist-to-patient ratio. Thus, while the original figure of 119 is equivalent to one psychiatrist for every 70 patients, this ratio should be adjusted to one per 105. Further, this varies considerably between hospitals. At Springfield, Maryland's largest facility, it is one to nearly 200. A psychiatrist cannot, of course, adequately treat this large number of patients. The extensive use of tranquilizers since 1954 has now made the raving and screaming inmate described by Howard Norton in 1949 an uncommon sight. Nevertheless, employee shortages, although often obscured by available data, continue to make the custodial long-term patient receiving minimal treatment services a very common sight.

5. The large scale use of general hospitals for the treatment of mental illnesses has been mentioned by an earlier speaker. This is not the case in Maryland. Outside of the Psychiatric Institute here at University Hospital and the Phipps Psychiatric Institute at Johns Hopkins, psychiatric beds are still virtually nonexistent in Baltimore area general hospitals. In the rest of Maryland, only the Peninsula Hospital at Salisbury and the Prince George's Hospital at Cheverly now have such functioning units. The former does not, as yet, report to the Register. The latter reported 774 admissions in 1964. By comparison, most of the major Washington general hospitals have psychiatric departments. Although reporting from these facilities to the Register is not complete, available data indicate that they treated a minimum of 750 Maryland residents in 1964.

6. The number of patients treated in the private psychiatric hospitals has increased, due to shortened periods of hospitalization and greater turnover. These facilities now provide fewer beds, however, since a number, such as the Cedarcroft Sanitarium at Silver Spring, have ceased to exist. Register data indicate that their patient load is heavily concentrated among the white middle and upper middle class in the middle years of life admitted for the short term treatment of psy-

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choneurotic and personality disorders. The alcoholic, the young, the old, the chronically ill are the exception. Even though segregation is not deliberately practised, the cost of treatment here effectively bars the Negro and other members of the lower economic classes from admission. Nine of Maryland's 11 privately operated psychiatric hospitals reported no non-white admissions to the Register during 1964. The remaining two had a total of 13. These accounted for less than 1% of the 1,422 admissions to these 11 facilities. By comparison, 27.4% of the 7,681 admissions to the six state operated psychiatric hospitals were non-white.

7. Register data indicate that outpatient facilities now care for the majority of all psychiatric admissions. These 80 community facilities in 1964 reported 12,868 admissions of 11,726 Maryland residents (the difference between these two figures reflects multiple admissions to the same or to different facilities). The majority of all outpatient admissions were under 25 years of age and 85% were less than 45 years of age. Only one percent were 65 years of age or older. Maryland now has outpatient facilities in Baltimore and in all except one of its 23 counties. Many of these are open for only a short period of time, usually on weekdays between 9:00 AM and 5:00 PM. They are in fixed locations and thus may be inaccessible to those who do not have means of transportation. The absence of evening or weekend clinic hours excludes many individuals who are employed and unable to take time off during regular working hours. Register data previously reported have shown that a majority of patients released from State hospitals on convalescent leave do not receive outpatient services.[3] Further, a paper recently presented by the Register staff showed that four out of five alcoholics admitted to three major state hospitals were not under any psychiatric care 18 months after admission and only three percent were receiving some type of outpatient service in a reporting facility.[4] Among psychotic patients, 76% had been released 18 months after admission. Of these, only 15% were under clinic care at that point. In the case of former hospital patients with psychoneurotic and personality disorders, 9% of the 89% who had been released were under outpatient care.

8. The rise in the number of alcoholic patients treated has been the most important factor in the rapid increase reported in admissions to the six State hospitals. In 1949 there were less than 300, or one out of every seven admissions. In 1965 there were more than 2,500 or more than one of every three. In 1949 alcoholics occupied 3% of the hospital beds; they now account for 6%. This increase may be attributed in part to changes in commitment laws and to the greater acceptance by the community, and by the alcoholic himself, of the State hospital as a treatment facility. Another factor related to this increase, however, is that alternatives to the State hospital continue to be virtually non-existent for the alcoholic. Register data indicate that alcoholics are rarely accepted for treatment in the private hospitals or in the psychiatric units of general hospitals. In comparison to the 2,500 who entered state hospitals, 126 alcoholics were admitted to private hospitals and 370 to general hospitals.

In Baltimore City there are only two clinics specifically for alcoholics (Psychiatric Institute and the Eastern Health District). Latest Register data show that they treated 427 patients at some time during a one year period. Only 5 of the 23 counties have clinics specifically for alcoholics. They reported a total of 285 patients under care during the latest one-year period. The State hospitals thus admitted twice as many patients for alcoholism as did all of these other facilities combined. For many alcoholics, a short hospitalization followed by extended community care is believed to be the best treatment method. That this is only infrequently employed has been shown earlier here. The number of alcoholics in Maryland's total population is not accurately known since an acceptable method for determining this figure has not yet been established, but it is estimated by the Department to be at least 70,000. This would indicate that only a small minority, probably in the neighborhood of 5%, are receiving any type of psychiatric services during any one year.

9. Register data indicate that 3,264 patients under the ages of 15 were admitted to psychiatric services in 1964. More than 90% of these went to outpatient facilities, with most of the remainder going to one of the State-operated hospitals. Data on children treated in outpatient facilities, particularly in the rural county-operated clinics, do not represent an accurate reflection of services provided since many of these patients are ad-

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mitted for evaluation and diagnosis rather than treatment. Where treatment is provided, it is usually as part of a general mental health clinic program. The number of clinics for children has remained small. The State hospital continues to be the major inpatient treatment facility for children since private psychiatric hospitals and general hospitals do not usually accept them. In 1964 there were 141 State hospital admissions under 15 years of age compared with 31 to private hospitals and 29 to general hospitals. Although there are some specialized facilities, such as Linwood in Ellicott City, these can handle only a small proportion of the children requiring such care.

In the State hospital system the Institute for Children is the major center up to the age of 12. Until a recent change in policy, however, many children were admitted to the other State hospitals. A number of special units for the treatment of adolescents have been developed on the grounds of these facilities, but these, too, are small in number and inadequate to meet the need. Therefore the majority of adolescents continue to be treated in wards with other patients, a policy which is not believed to be conducive to the recovery either of the adolescent or of the adult.

One major difficulty here, as in other areas, is that Maryland suffers a chronic shortage of professional personnel. For example, data available from the American Psychiatric Association indicate that there are only six Board Certified Child Psychiatrists in Maryland, of whom three are in the Baltimore area. Maryland's population includes 725,000 residents between the ages of 5 and 14. The limitations indicated here reflect a continuous, growing problem with no immediate prospect for major relief. In 1966 it is Maryland's cause for shame.

10. The State hospitals also continue to be the major treatment facilities for the older person requiring services for mental conditions. Their reported 917 admissions of patients 65 years of age or older compare with 227 to private hospitals, 150 to general hospitals and 267 to outpatient facilities. Thus, nearly 60% of admissions in this age group were to the State hospitals. This group now occupies 2,500 beds. Most receive only minimal services. There has been a slight decrease in their number, due mainly to a mortality rate which exceeds 25% per year. Deaths in this group continue to exceed the number released.

This paper has concerned itself with changing patterns in psychiatric care in Maryland. It has been shown here that major improvements in services for the mentally ill have occurred, particularly in the 17 years since publication of "Maryland's Shame," but that deficiencies continue to exist in many areas. Some examples of these have been cited. It should be recognized that, for the child, the senior citizen, the alcoholic and many other groups, required specialized services continue to be available only on a minimal basis. For many of these it would be incorrect to speak of psychiatric care since this remains virtually nonexistent. It would therefore appear that the title of this paper should athe have been "Changing Patterns of Mental Health Services in Maryland."

The development of comprehensive mental health centers as a key part of a total program for meeting Maryland's mental health needs, offers a brighter future for psychiatric care. It should be noted in conclusion that the original concept of this plan, and most of its cost, came from the Federal Government. This is one indication of rapidly expanding national participation and involvement in state and local mental health programs. It is one of the major steps forward in the gradual evolution from the concept of the mentally ill as the sole concern of the county or local municipality.

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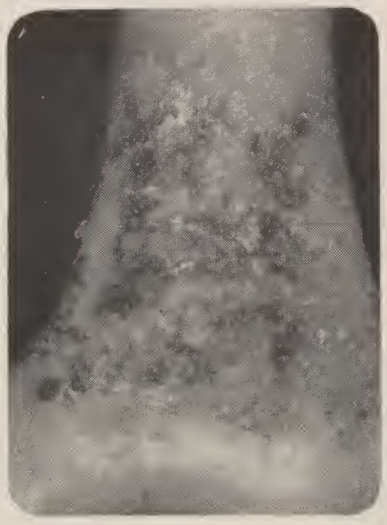
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"'Tranquilizer' is not a good word"[1]

THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

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DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

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Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

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*Based on 4 cc. per teaspoonful.

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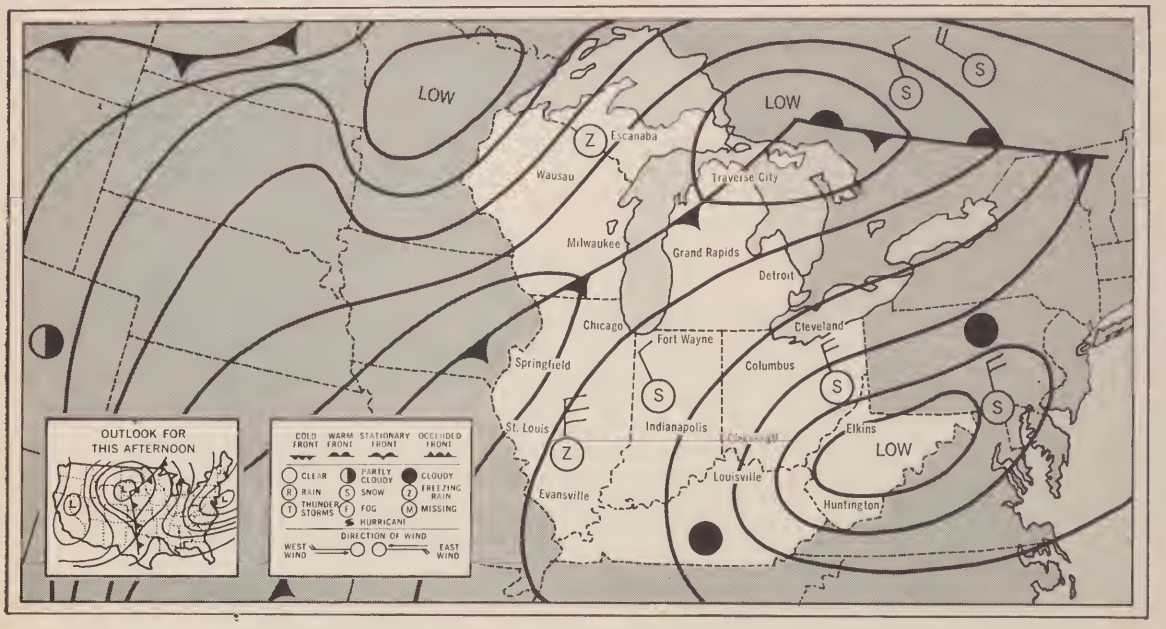
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ACHALASIA: PRESENT CONCEPTS AND THE PRESENTATION OF THREE CASES

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Three cases of achalasia of the esophagus are presented. The present understanding of this entity and newer techniques in the methodology of diagnosis are reviewed. Surgical management and pneumatic dilatation are compared. It is suggested that esophagomyotomy be reserved for the small number of failures encountered after pneumatic dilatation, in the very young or where neoplasm can not be excluded.

Achalasia is a neuromuscular disorder characterized by failure of the terminal esophagus to relax during deglutition due to absent or ineffectual peristalsis throughout the body of the esophagus.[1, 2] It is frequently called cardiospasm, but present evidence favoring a motor defect in the body of the esophagus makes this occasionally used term obsolescent.

The first description of achalasia was that of Thomas Willis of Oxford. In 1672 he first treated the condition with a bougie consisting of a piece of whale bone on the end of which was tied a sponge.[3] Since his early report, recognition of the disorder as an entity has increased with the advent of newer diagnostic methodology. Its exact incidence is unknown, but it should not be thought of as rare in occurrence. Achalasia is nevertheless uncommon enough to present the practicing physician with many uncertainties with respect to its diagnosis and management. The purpose of this report is to review the present understanding of this disorder and the expected therapeutic result of treatment with the presentation of three cases.

Three Cases

Case No. 1

L. P., a 42-year-old white male, was admitted to the hospital because of progressive dysphagia and regurgitation of three months' duration. He had first experienced difficulty in swallowing solid food, which he indicated would stick in his chest at the level of the xiphisternum. He had relieved the dysphagia at an early stage by forcing the food past this point with liquid. From the time he first noted symptoms to the date of admission, he had lost 37 pounds.

Later in the course of the disease, he had vomited recognizable food after meals and, on some occasions, food he had ingested two or more days previously. When asked specifically, he stated that he had also noted secretions on his pillow in the morning which he had attributed to "slobbering" during his sleep. His physical examination was pertinent in that he showed obvious weight loss, and when an attempt was made to establish his "swallowing time," an esophageal squirt was not demonstrable.

His hematogram was normal. No blood was demonstrable in the stool. Routine blood chemistries were normal. The upper gastro-intestinal roentgenogram revealed marked dilatation of the body of the esophagus, with a smooth tapering constriction at the esophagogastric junction (Fig 1a). Esophageal motility studies revealed no progressive peristaltic contractions. Mecholyl (5 mg injected subcutaneously) initiated a marked elevation of the resting baseline intra-esophageal pressure with the simultaneous development of "spastic," non-progressive bursts of esophageal motor activity. Esophagoscopy demonstrated a markedly dilated esophagus, the distal end of which was closed, but could be traversed by manipulation of the esophagoscope. Endoscopic inspection of the cardio-esophageal junction was normal.

The patient was taken to the radiology department, and under fluoroscopic guidance, the Tucker-Hurst pneumatic dilator was placed at the esophagogastric junction. The bag was inflated to 15 pounds of pressure, which caused straightening of the concave distortion of the pneumatic bag present at the esophagogastric junction. The immediate post-dilatation period was uneventful, his dysphagia disappeared within twenty-four hours and (as of the date of preparation of the manuscript) he has remained asymptomatic for the ensuing nine months. Post-dilatation x-ray (Fig 1b) shows less dilatation after a barium swallow.



Fig 1a

Barium swallow picture, Case No. 1, before pneumatic dilatation



Fig 1b

Barium swallow picture, Case No. 1, after pneumatic dilatation

Case No. 2

A. W., a 47-year-old Negro female, was admitted to the hospital for vomiting and difficulty of swallowing. Symptoms dated back to three years prior to admission when she first noted sharp epigastric pain soon after each meal. It was



Fig 2a

Barium swallow picture, Case No. 2, before pneumatic dilatation

relieved by drinking liquid. Her difficulty progressed until pain occurred during the ingestion of solid food or liquid. It was relieved only by vomiting. Throughout the course of her illness she had a marked weight loss, but commented that her desire for food remained good. The patient learned by experience that if she ate slowly, chewed carefully and swallowed several times with each mouthful of food, she would have less discomfort. In addition, she noticed frothy materials and undigested food on her pillow upon awaking from sleep.

Physical examination and routine laboratory studies were entirely within normal limits. The upper gastrointestinal x-rays showed a markedly dilated esophagus, with an obstruction at the esophagogastric junction (Fig 2a).

The roentgenologist commented that no peristaltic activity was demonstrable in the body of the esophagus during fluoroscopy.

The esophageal motility test demonstrated a failure of the high pressure zone to relax with deglutition and showed that each swallow initiated a burst of simultaneous, nonprogressive contractions. The mecholyl test was markedly positive. The patient was esophagoscoped and no evidence of an obstructive lesion at the cardio-esophageal



Fig 2b

Barium swallow picture, Case No. 2, after pneumatic dilatation

junction was found.

The patient underwent pneumatic dilatation with the Tucker-Hurst dilator fluoroscopically placed and in gradually increased pressure until straightening of the cardio-esophageal junction was observed at 15 pounds of pressure. She experienced dramatic relief from her symptoms soon afterwards, and has gained 28 pounds in a period of six months. The post-dilatation barium swallow showed a less dilated esophagus (Fig 2b).

Case No. 3

A. N., a 78-year-old white female, was admitted to the hospital for fever, cough and chest pain on the right side of ten days' duration. Subsequent "work-up" revealed a right lower lobe pneumonitis. During her hospital course, it was noted by the nurses that the patient took extremely long periods to eat and had frequent paroxysms of cough during meals. When the patient was questioned specifically for symptoms related to swallowing, she denied difficulty of swallowing but reported increased "choking" during meals. Subsequent x-rays revealed marked dilation of her esophagus, with obstruction at the cardio-esophageal junction (Fig 3a). Marked "curling" of the esophagus was evident, as well as prominent "vallicular sign."

Esophagoscopy revealed dilation of the body of the esophagus, but the cardio-esophageal junction appeared normal. The patient was dilated with the pneumatic dilator in the usual manner. Subsequently she has been free of respiratory symptoms. The patient was not aware of swallowing difficulties before dilatation, but stated that eating and swallowing "felt so much easier" after the procedure. She has gained 27 pounds during the past fifteen months. The post-dilatation x-ray is shown in figure 3b.

Clinical Manifestations

The most prominent symptom presented by patients with achalasia is that of dysphagia. This, however, may be overshadowed on occasion by respiratory difficulty, overwhelming weight loss and cachexia. While dysphagia was prominent in Cases 1 and 2, the patient in Case 3 was not really cognizant of it until after she had undergone dilatation of her esophagus. This lack of awareness, not uncommonly encountered, is best explained by adaptive changes in the patient's eating habits which may ensue, ie, a preference for soft foods, slow eating, monotonous chewing, and liquid- or air-swallowing to force a bolus into the stomach.

As the obstruction becomes more severe, vomiting is seen to become a more prominent feature. This vomiting is characteristically peculiar in that it is not associated with nausea and the vomitus often contains recognizable food stuffs ingested during meals in either the immediate or the recent past. Since the material vomited has never been allowed to mix with gastric secretion, it does not contain hydrochloric acid[4] and it is not associated with pyrosis, or the usual burning acid taste. As retention within the megaesophagus increases, the patient finds he cannot lie flat because of "spilling over" of the constantly full esophagus. The latter accounts for soiling of the pillow observed in Cases 1 and 2, and nocturnal paroxysmal cough seen in Case 3.



Fig 3a

Barium swallow picture, Case No. 3, before pneumatic dilatation

The physical findings in patients with achalasia are not specific. The outstanding features include weight loss, associated signs of malnutrition and, usually, the inability of the examiner to elicit a swallowing time. In those patients in which aspiration is prominent, one will observe signs and symptoms referable to the associated respiratory involvement.

Roentgenologic Changes

The routine chest film in achalasia may show widening of the mediastinal shadow produced by the megaesophagus.[5, 6] This finding is occasionally mistaken for an aortic aneurysm[5] or mediastinal tumor.[6] The barium swallow of patients with achalasia is remarkable during the fluoroscopic examination in that an absence of progressive peristalsis is the rule. The barium will be seen to traverse the body of the esophagus, then to be delayed at the esophagogastric junction. This abnormality accounts for the ability of the malady to support a barium column, a prominent feature important in its roentgenologic recognition. It is therefore mandatory that these patients be studied in the upright position.[2] Roentgenologically, achalasia raises the differential diagnosis of benign vs malignant obstructive esophageal disease. Characteristically, the obstructive lesion in achalasia is one of a tapering "bird beak" appearance of the distal esophagus terminating at the gastric cardia, while that of neoplasm is an abrupt, shelf-like deformity. Achalasia may be associated with neoplasm, however, and therefore carcinoma must be considered in all instances.[7] Associated roentgenologic features of achalasia frequently include the absence of a gastric shadow, signs of aspiration, and occasionally the "vallicular sign."



Fig 3b

Barium swallow picture, Case No. 3, after pneumatic dilatation

Endoscopy

Esophagoscopy is helpful and necessary in the diagnosis and management of all cases of achalasia because of the ever looming possibility of other obstructive processes. Upon entering the esophagus, the endoscopist frequently encounters a dilated, cavernous structure, usually filled with retained secretions. As he proceeds with his examination, he is impressed with the relatively normal appearance of the esophageal mucosa. In the distal esophagus, it is usually observed that the dilated body of the esophagus tapers in a regular fashion to a closed esophagogastric junction. With careful manipulation, the endoscopist is able to enter the cardia of the stomach, and to look for features other than normal mucosal configuration. Should doubt arise as to the nature of the obstructive lesion, biopsy is necessary.

Pathophysiology

The microscopic features of this condition are associated with either a decrease or a complete absence of ganglionic cells from the myenteric nerve plexus.[8, 9] Whether these findings are on a congenital or degenerative basis has been the subject of much debate and is beyond the scope of this report. Pertinent to the understanding of the pathophysiological changes, however, is that this deficit is associated with the interruption of autonomic motor pathways allowing motor activity to occur in an erratic manner and accounts for the diagnostic response to mecholyl, a synthetic

parasympathomimetic drug. The latter response is in accord with Cannon's law, which stated that "a tissue deprived of its autonomic nerve supply is excessively sensitive to the chemical transmitter of the nerve impulse, and is held to be pharmocological evidence of partial or complete aganglionosis."[10]

Esophageal Motility

With the advent and refinement of manometric esophageal studies, much progress in the diagnosis of achalasia has come into being. Code et al,[11] in a study of one hundred patients with achalasia, showed that the essential abnormality was the absence of progressive peristalsis in the body of the esophagus, and a failure of relaxation at the cardioesophageal junction. In other words, deglutition was followed by normal criopharyngeal function; erratic, spastic, non-propulsive or no motor activity in the body of the esophagus; and a failure of relaxation or even contraction at the cardioesophageal junction.[12] A diagrammatic manometric record of a four-channel simultaneous recording obtained with water-filled catheters, five cm apart, is shown in Figure 4. In addition, the characteristic manometric response in achalasia to the subcutaneous injection of mecholyl in accord with the "law of Cannon" results in an elevation in the baseline pressure and the initiation of spastic activity (shown for comparison in Figure 4).[13]

Management

It is unfortunate that most reports of this condition are written either by physicians who tend to overstress dilatation and decry operative

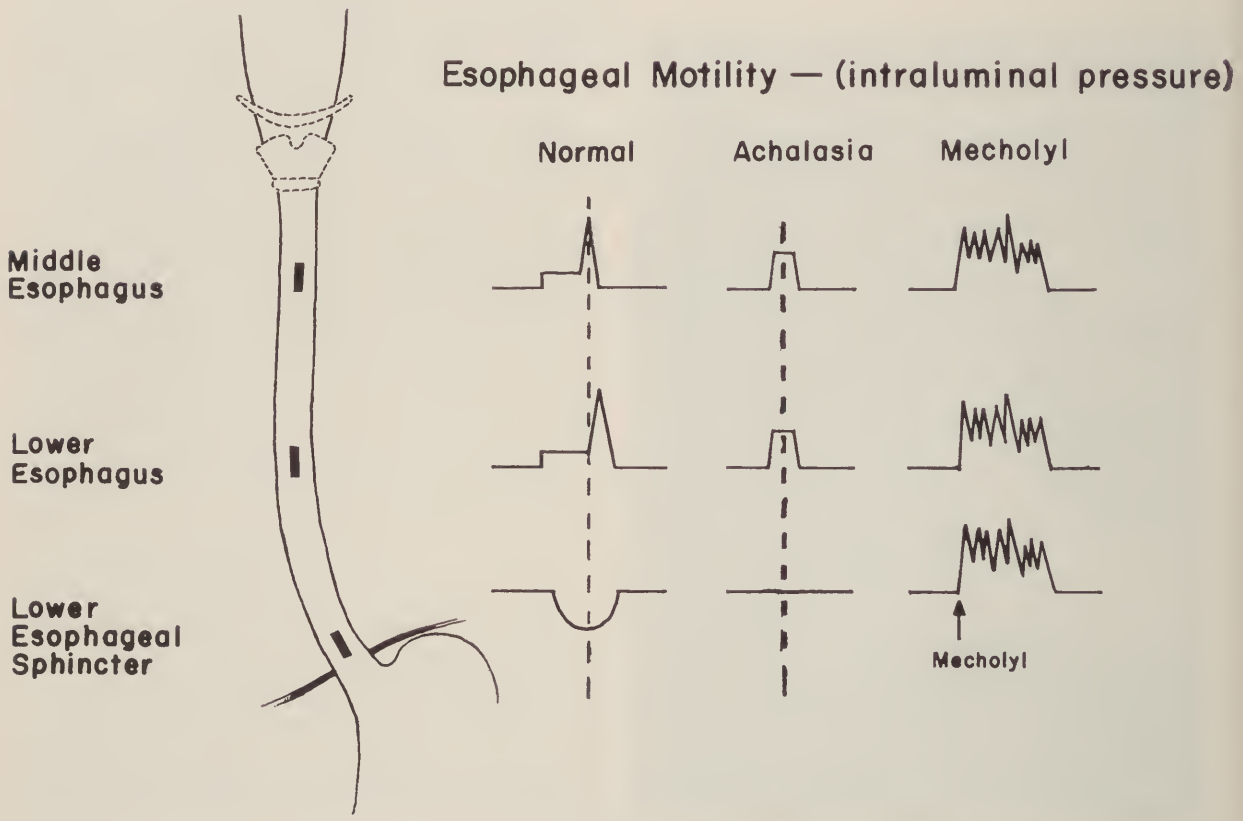


Fig 4

Esophageal motility comparing pressure changes occurring in the areas depicted at the left (1) in the normal, (2) in achalasia, and (3) in response to subcutaneous injection of mecholyl.

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treatment or by surgeons who report series treated by operation only and condemn the uncertain results of dilatation. The advantages of the expanding bag dilatation are that it can be carried out under local anesthesia with little discomfort to the patient and with great financial saving. Whenever the same result can be achieved by simple method with little risk and low morbidity, then such is, needless to say, to be advocated over the more complex method. This, however, may not always be possible, especially when the disease is encountered in the very young or in instances when malignancy is strongly suspected.

The results of expanding bag dilation vs surgical procedures are not statistically different, as indicated by Schindler,[14] who claimed 95% good result with a series of 84 patients by medical management, or Olsen et al,[15] who reported 100% excellent and immediate results in 57 patients treated surgically. The follow-up period of these patients, which extends from six months to six years, with a mean of two years, gave a 94% excellent result. These findings can be compared with the report by Payne, Ellis and Olsen,[16] who in 1960 claimed an excellent or good result in approximately 80% of patients treated with esophagomyotomy. It is significant that Steicher, Heller (originator of Heller's procedure) and Ravitch wrote in 1960 that "through the years most authors have agreed and still agree that approximately 70% to 80% of all patients with achalasia can be cured by one or several dilatations."[17]

Long term follow-up showing the efficacy of pneumatic dilatation is reflected in the report of Kurlander et al,[1] who reported that in 84% of 62 patients, a continuous asymptomatic state existed for 30 years after dilatation. Surgical procedures such as the esophagomyotomy (Heller's procedure) should, therefore, be reserved for the small number of failures encountered after pneumatic dilatations have been attempted.

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Names and addresses of above physicians received too late to appear in the Directory of Registered Physicians.

History of the Baltimore City Hospitals

BY DOUGLAS CARROLL, M.D.



Chapter 12.—Some Problems of the Future

"The future confronts us with multiple uncertainties. The only assured facts are that circumstances and their issue have changed and that the what and the ways of time past are no longer entirely adequate, effective or rewarding."[1]

Perhaps the outstanding purpose of the Baltimore City Hospitals throughout its 200 years has been to meet community health and welfare needs not being met by other public and private organizations within the city. Initially, it was the depository for vagrants, prisoners awaiting trial, the elderly and infirm, foundlings, and the insane. As Baltimore developed, many of these functions were taken over by other organizations, mainly State supported institutions. It is logical to assume that the Baltimore City Hospitals will continue to respond to those needs of the community which cannot otherwise be met.

The hospital has been particularly fortunate in being able to develop an administrative organization which is sensitive to the needs of (1) the community and the medical profession, for the provision of medical care, (2) the medical schools, for teaching, and (3) the Department of Public Welfare, for care of the indigent, and, at the same time, to be sufficiently independent and free to meet existing and potential problems in its own way. This freedom is formalized in several basic and documented rules by which the future development of the hospital will be guided:

1. Visiting and staff physicians must have University Medical School appointments

The purpose of this rule is to assure the care of Baltimore City Hospitals, patients, and the teaching of house staff and students, by the foremost physicians of Baltimore. Although medical school staffs had been involved in the care of patients throughout the hospital's existence (since 1790), this required that *all* members of the visiting staff have appointments at the medical schools. Originated by Alan M. Chesney, MD, the rule was documented at a meeting of the Medical Advisory Board on April 7, 1934: ". . . provision (is to) be made for the appointment of a Junior Visiting Staff, the members of which will be responsible to their respective chiefs of services for the care of the patients who are assigned to them. The members of this staff should be recruited from the faculties of the two schools of medicine in as nearly equal proportions as the circumstances will permit."

2. Appointments of chiefs of service are to be the Joint Responsibility of the two Medical Schools and the Baltimore City Hospitals.

This agreement was worked out in 1961 after a good deal of acrimony between and among the Board of Estimates of the City of Baltimore, the Staff Conference Committee of the Baltimore City Hospitals, and the Medical Schools. It is a unique agreement between a Municipal Hospital and Medical Schools. It recognizes, on the one

hand, the hospital's right and responsibility to participate in the selection of Chiefs of Service (to fulfill patient care responsibilities) and, on the other, the right of the Medical Schools to have priority on certain services for student teaching (to assure continuity and planning of teaching).

Baltimore City Hospitals—Medical Schools Agreement, Dec 5, 1961

"In recent years there has been a country-wide trend towards close arrangements between City or County Hospitals and Medical Schools in the same community. This has proved to be productive of higher standards of medical care to the mutual advantage of the medical schools, the hospitals, and the community.

"The Department of Public Welfare of Baltimore City, and the staff of the Baltimore City Hospitals, are firmly convinced that their primary aim of providing the best possible medical care to their patients will be best served by strong medical school ties. The quality—and number—of the house officers and staff physicians who can be recruited to care for patients at the Baltimore City Hospitals will depend, to a considerable extent, upon association with the medical schools. The advantages to the city of close medical school associations stem essentially from the increased opportunity for staffing Baltimore City Hospitals with the most capable physicians at all levels,—with the obvious resultant benefits.

"The Baltimore City Hospitals is not, and is not likely to become, of a size such as to make it feasible, or advisable, to divide each of the services between the two medical schools in Baltimore.

"Baltimore City Hospitals reaffirms its intent to provide teaching opportunities to medical students from both the University of Maryland School of Medicine and the Johns Hopkins University School of Medicine. Equal opportunities for students from both schools will be offered on all services, within the limits of the needs of the two schools and the potentialities of the respective services.

"Along with these undergraduate teaching responsibilities and duties which are the proper concern of the two medical schools, the Baltimore City Hospitals has comparable responsibilities and duties in the post-graduate training and teaching of its house officers. For this training and teaching, neither medical school can assume full responsibility. The over-all teaching program at the Baltimore City Hospitals has evolved in such a way that the needs of students and house officers have been met by close integration within

"We go about our work, I hope and I believe, as quietly, as sturdily, and as sensitively as we know how, giving our diuretics, our antibiotics, our tranquilizers; without shrinking, without apologizing, and without insisting on sifting out definitively the moral and ethical aspects of the patient's illness beforehand, when our job is to care for him."[8]



John O. Neustadt, MD
(1916-1964)

Tank company commander, college dean and teacher, journalist, physician. BA, MA, St. John's College, Annapolis (1939 and 1942); Captain in Armor, AUS (1942-1946); MD, Johns Hopkins University School of Medicine (1952); assistant resident in medicine, Baltimore City Hospitals (1953-1954); first full-time chief of psychiatry, Baltimore City Hospitals (1961-1963).

the services. In addition, joint teaching and clinical sessions are held by several services. This inter-service cooperation has made it possible to develop mixed internship and residency programs designed to provide family practitioners for the community as well as specialists.

"All members of the professional staff of the Baltimore City Hospitals will continue to be required to hold faculty appointment in one of the two medical schools.

"Members of the house staff of the Baltimore City Hospitals will be eligible for consideration for appointment as Fellows in the University of Maryland School of Medicine and the Johns Hopkins University School of Medicine.

"The agreement which follows is designed to provide proper teaching facilities for the medical students of the two medical schools and to insure the continued availability of the Baltimore City Hospitals as an institution for the hospital care of the sick of the community and for the training of physicians in the practice of medicine:

AGREEMENT

"To assure continuity, direction and supervision of student teaching programs, each medical school will have priority on designated services. Such teaching priority will not be interpreted as excluding students from the other school from participating in the teaching activities of the service.

Student Teaching Priority Assignments

University of Maryland	Johns Hopkins University
Anesthesiology	Medicine
Obstetrics & Gynecology	Pathology
Radiology	Pediatrics
	Psychiatry

"The Johns Hopkins University School of Medicine will continue to have teaching priority on the surgical service during the tenure of the present Chief of Service. The University of Maryland School of Medicine will then have the option of assuming teaching priority on this service. Integration of functions among the services is of paramount importance. Inter-service coordination necessitates consideration of the effect of a change in any priority assignment on priorities on all services.

"Vacancies in the position of Chief of Service will be filled in accordance with the following procedure:

(1) A Chief of Service will be nominated by a committee on which there will be equal representation from the University of Maryland School of Medicine, the Johns Hopkins University School of Medicine, and the Baltimore City Hospitals.

(2) The committee member from the University of Maryland School of Medicine and the Johns Hopkins University School of Medicine will be designated by the respective schools. The committee member from the Baltimore City Hospitals will be a Chief of Service and will be appointed by the Chairman of the Medical Advisory Board. Each of these committee members shall have the right to vote.

(3) The representative of the medical school with priority will be chairman of the committee. The Director of Baltimore City Hospitals will serve as secretary of the committee but will not have the right to vote.

(4) Nominations will be unanimous. Each member of the committee with the right to vote shall have the power to veto. Nominations so made will be subject to the approval of the governing bodies of the faculties of the two medical schools to ensure the faculty status of the nominee at one or both medical schools and transmitted subsequently to the Medical Advisory Board of the Baltimore City Hospitals for its action.

(5) Upon approval of the Medical Advisory Board of the Baltimore City Hospitals, the nomination will be transmitted to the Advisory Board of the Department of Public Welfare for its action.

"Arrangements for salary supplementation by the medical schools in each instance will be negotiated between the candidate chosen and the medical schools in accordance with the stipulations of the Board of Estimates.

"This statement of policy shall continue in force until terminated or modified by mutual agreement, or it may be terminated at the election of any of the parties at the expiration of twelve months from the date of service of a written notice by one of the parties, stating a desire to terminate same."

3. The Hospital has Separate Status

In November, 1965, by vote of the people of Baltimore, the Baltimore City Hospitals was separated from its long association with the Baltimore City Department of Welfare and given separate status as the Department of Hospitals. The Hospital had prospered under the Department of Welfare and the separation was based more on the increasing size and importance of the Hospital than on any difficulty under the Department of Welfare.

Department of Hospitals

49. DEPARTMENT OF HOSPITALS—Organization and Powers:

(a) There shall be a Department of Hospitals, the head of which shall be the City Hospitals Commission whose membership shall include six appointed citizens who shall be informed as to the problems of hospital operation and the methods of hospital care, but who shall not be members of the medical or dental professions. They shall be appointed by the Mayor in the manner prescribed in Section 6 of Article IV and shall hold office as therein provided, except that they shall be appointed for terms of six years, two of them to expire at the end of every two years; provided that the first members shall be appointed to terms, two of which shall expire at the end of the first calendar year following the

calendar year in which the appointments are made, two of which shall expire at the end of the third calendar year following the calendar year in which the appointments are made, and two of which shall expire at the end of the fifth calendar year following the calendar year in which the appointments are made. In addition to those appointed, the Director of Welfare shall be a member of the Commission ex officio. The members of the Commission shall serve without compensation. The Mayor shall designate one appointed member of the Commission as its Chairman and may, from time to time, withdraw such designation and designate some other appointed member as Chairman of the Commission.

(b) The City Hospitals Commission shall be responsible for the organization and policy of the City Hospitals and shall make and put into effect such plans and procedures as in its judgment may be necessary or advisable to carry out the responsibilities of the City Hospitals, including the hospitalization and treatment of ill or injured persons, the carrying on of medical and health research, and the education of health personnel.

(c) The Department of Hospitals shall have a Director who shall be appointed by the Mayor in the manner prescribed by Section 6 of Article IV and shall hold office as therein provided, except that his term of office shall be for six years and his appointment shall be made upon the advice and prior approval of the City Hospitals Commission; provided, that, in the first instance, the person holding the position of Director of City Hospitals in the Department of Welfare shall become the Director of Hospitals on the applicable effective date as determined under Article IX and shall serve in accordance with the provisions of the Charter relating to the Classified Civil Service. The Director shall be responsible for the proper conduct and operation of the Department and shall appoint such assistants, aides and employees as may be provided in the Ordinance of Estimates; provided, however, that the assistant directors, department heads, chiefs of services, and heads of any institution managed by the Department must first be approved by the City Hospitals Commission.

Questions for the Future

History teaches us that the formulae of the past are not adequate for the future; not only do the methods of meeting problems change, but the questions requiring answers are different. Following are some questions about the future which can be expected to arise in relation to the Baltimore City Hospitals. These questions have to do with potential financial and personnel resources available to hospitals of the future, with attitudes toward, and goals of, medical care, and with the methods of carrying out these goals.[2]

1. Who will decide patient needs?

At the present time, the purely medical needs of patients for diagnosis and treatment of acute

"It is imperative that the training of our young doctors should, by high example, include exposure to the fact that compassion and intellectualism can be combined without loss of scientific excellence. It is also imperative that our system for the provision of medical care be so organized that the atrocities of medical neglect no longer occur. In this day of the somewhat tarnished image of the American physician, the modern deputies must speak out to end the unnecessary suffering of many of the chronically ill and aging and their anguished families. Is this a vain hope?"[9]



Mason Faulconer Lord, MD
(1926-1965)

Patron of the arts, community leader, philanthropist and physician. BA, Princeton University (1950); MD, Johns Hopkins University School of Medicine (1954); intern (1954-1955), assistant resident (1955-1957), resident (1958-1959), Baltimore City Hospitals; first full-time chief, chronic and community medicine, Baltimore City Hospitals (1963-1965).



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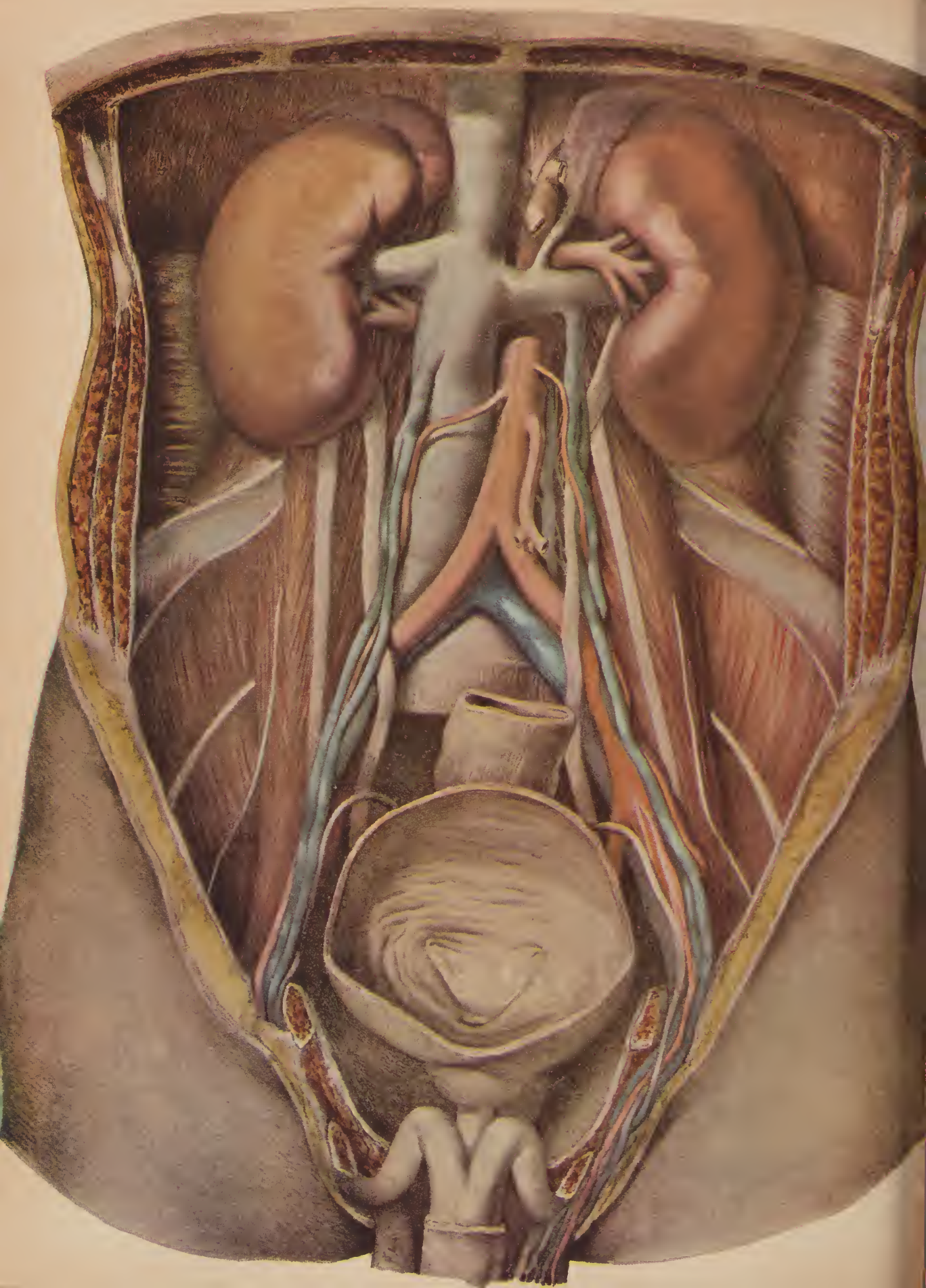
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disease (including the specialties) are being met at a high level. As newer expensive diagnostic methods are developed, as new specialties arise, costs will increase. Recently developed artificial hearts, artificial kidneys and cardiac pacemakers are forerunners of difficult, and therefore expensive, discoveries of the future. Is each patient to receive the best possible treatment, or are criteria to be set up (for example, in the case of possible use of the artificial kidney) as to who is eligible for certain treatments? Who will make these decisions?

In the care of patients with chronic diseases, there are social, housekeeping and hotel functions which are not purely medical, but bear on the medical care of the patient. Who will decide what amenities the hospital shall offer?

Under Medicare, many of these decisions may rest on the Hospital Utilization Committee, but ultimately perhaps on the Federal Government.

2. What is the Community or Federal Government willing to pay for Good Medical Care?

Medical costs will continue to rise, particularly for care of patients with chronic diseases. This area is where medical care is farthest behind in nursing homes, rehabilitation, diversional activities, mental diseases and alcoholism. The more severe the disability, the more costly and prolonged the treatment—with smaller returns in terms of returning patients to productive capacities.

Closely related to this question is, "What can the community or government afford to pay toward medical care?" Apparently it can pay whatever it is willing to pay if the "affluent society" continues.

It is a mistake, however, to put the problem of available resources purely in economic terms. Money alone does not insure good medical care. Human resources, in terms of people who are willing to spend their lives in all phases of hospital work, must be attracted and satisfaction in the work must be supplied. The quality of care given depends upon the quality of hospital personnel in the lowest to the highest jobs.

3. What will be the effect of the increasing trends toward specialization, bureaucracy and third party payments on medical care?

Each of these movements arose in response to a problem. Specialization in the hospital and medical school arose because one man could not be proficient in all fields and because there were enough patients collected in the hospital to allow the specialist to make a living dealing with selected patients. With specialization, concern with the disease rather than the patient resulted.

Bureaucracy arose in an attempt to deal efficiently and rationally with large numbers of people by a common prescribed method.[3, 4]

Third party payments arose out of the increasing effectiveness of medical diagnosis and treatment, a rise in expectations as to what health care could accomplish, the poor distribution of medical care, and the rise in cost of medical care.

Each of these trends solved essential problems, but brought with it new difficulties. Together, all three have conspired to treat the patient as a thing rather than a person, to isolate the patient from essential emotion support, and to change the practice of medicine from a vocation to a profession, with probable deleterious effects on the quality of those entering medicine.

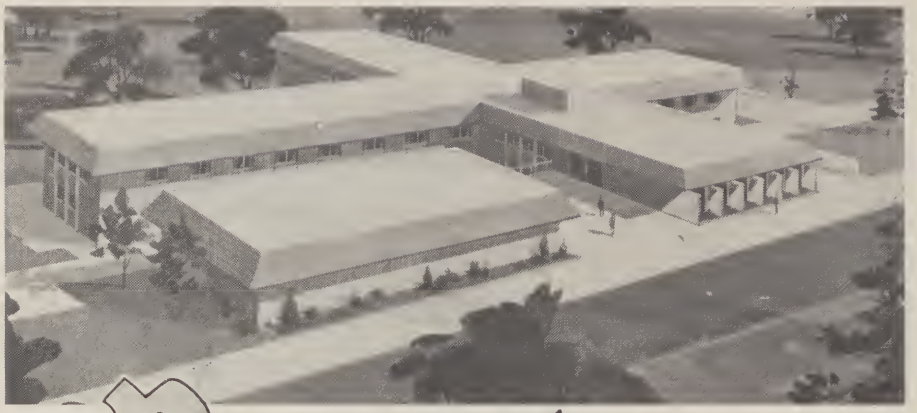
Postscript and Acknowledgements

Hospital histories are written for various purposes: some in praise of famous men; some as apologias; some as preludes to financial drives; some in celebration of an anniversary; some to trace the development of scientific medicine.

This history of the Baltimore City Hospitals has had a completely different purpose. It has been an attempt to understand the scientific, social, cultural, philosophical and governmental forces which have influenced the evolution of an institution from an almshouse to a hospital. A hospital today can fulfill its purpose only when the community is sympathetic to its aims and is willing to make sacrifices to assure good medical care. Social forces shaping hospital care are rapidly growing. It is important for the physician to understand these forces, if he is to channel his professional activities most effectively toward better medical care.

* * * *

The author would like to express his gratitude to Louis M. E. Krause, MD, for making available his collection of material on the Baltimore City Hospitals; to the late Drs. Alan M. Chesney and Maurice C. Pincoffs for their warm encourage-



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ment; and to the Chiefs of Services at the Baltimore City Hospitals, Miss Lena Van Horn and Miss Myrtle Dooley, who read the manuscript and made helpful suggestions.

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Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

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As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

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As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

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COMPONENT MEDICAL SOCIETIES

ANNE ARUNDEL COUNTY

The Anne Arundel County Medical Society held its regular October meeting at the Coachman's Inn on Ritchie Highway on October 19. A good representation of the Society membership was present. Following the usual cocktail hour and dinner, the meeting was called to order by the president, **Logan Holtgrewe, MD. W. J. Peebles, MD,** Commissioner of Health for the State, was the speaker of the evening. He talked about the State Medical Aid Program, its problems, and possible future developments. **Dr. D. T. Boyd,** assistant commissioner of health for Community Health Services also made a few comments. A number of questions were raised from the floor and were discussed.

In keeping with the by-laws, three new members, **Drs. Charles Hargrove, Horace Cholmondeley,** and **Robert O. Biern** were elected to the Society as associate members.

A system of radio paging and communications through an answering service was briefly mentioned. It was suggested that interested individuals could contact **Samuel Borssuck, MD,** or the Annapolis Message Center for further details which would be available as soon as they were more clearly defined and worked out. It was suggested that this could help towards the ever growing problem of reaching physicians outside their usual office hours.

The annual election of officers will be held at the next regularly scheduled meeting and the nominating committee, consisting of Dr. Borssuck as chairman and four past presidents of the Society, were instructed to bring nominations to the Society in accordance with the by-laws.

Samuel Borssuck, MD

WASHINGTON COUNTY

The Washington County Medical Society met at the Venice Motel on Thursday, September 22, 1966, with members of the Washington County Bar Association and of the Washington County Ministerial Association as invited guests.

Edward Davens, MD, Deputy Commissioner of Health for the State of Maryland, was the speaker. His topic was "Maryland's Medical Assistance Program," the program administered under the provisions of Title XIX of Public Law 89-97, better known as the Medicare Act.

The second part of the program was devoted to a panel discussion on the interrelationship of law, medicine, and religion. Two lawyers and two clergymen participated on the panel, and **William Beckner, MD,** chairman of the Medico-Religious Committee of the Medical Society, served as moderator. **James W. Banks, MD,** chairman of the Medico-Legal Committee of the Medical Society, served as co-chairman with Dr. Beckner in planning the joint meeting.

Two members of the Medical Society were honored as past presidents of the Medical and Chirurgical Faculty of the State of Maryland. **Bender B. Kneisley, MD,** who served as president in 1954, and **Robert vL. Campbell, MD,** who served as president in 1965, were each presented with a properly engraved plaque commemorating the year of service.

* * * * *

John W. Clark, MD, DDS, Hagerstown plastic and reconstructive surgeon, attended the International Meeting of the Latin American Society of Plastic Surgery in Lima, Peru, October 10 through 22. Dr. Clark presented two papers in Spanish, using illustrations and displays to supplement his lectures. His topics were "Repair of Facial Bone Fractures" and "Forehead Flaps."

Dr. Clark has been in private practice for the past five years in Hagerstown; he is married and has four children. Mrs. Clark and his two older children accompanied him on the trip.

Dr. Clark is a diplomate of the American Board of Plastic and Reconstructive Surgery, and a fellow of the American College of Surgeons and of the American Association of Maxillofacial Surgeons. He is secretary of the Washington County Medical Society.

* * * * *

Two local physicians played prominent roles in the 20th annual meeting of the Heart Association of Maryland held in Gaithersburg in October.

John C. Stauffer, MD, a representative of the Washington County Heart Association, was installed as vice-president of the State association.

Richard A. Young, MD, received the Heart Association's silver service recognition award for outstanding service over the years to both the Washington County and Maryland groups.

Charlotte R. Warden
Executive Secretary

WICOMICO COUNTY

Walter J. Levinsky, MD, associate professor of Medicine at Temple University in Philadelphia, was guest speaker at the October meeting of the Wicomico County Medical Society in Salisbury. Dr. Levinsky's topic was "Psycho-Therapeutic Agents: Do's and Don'ts."

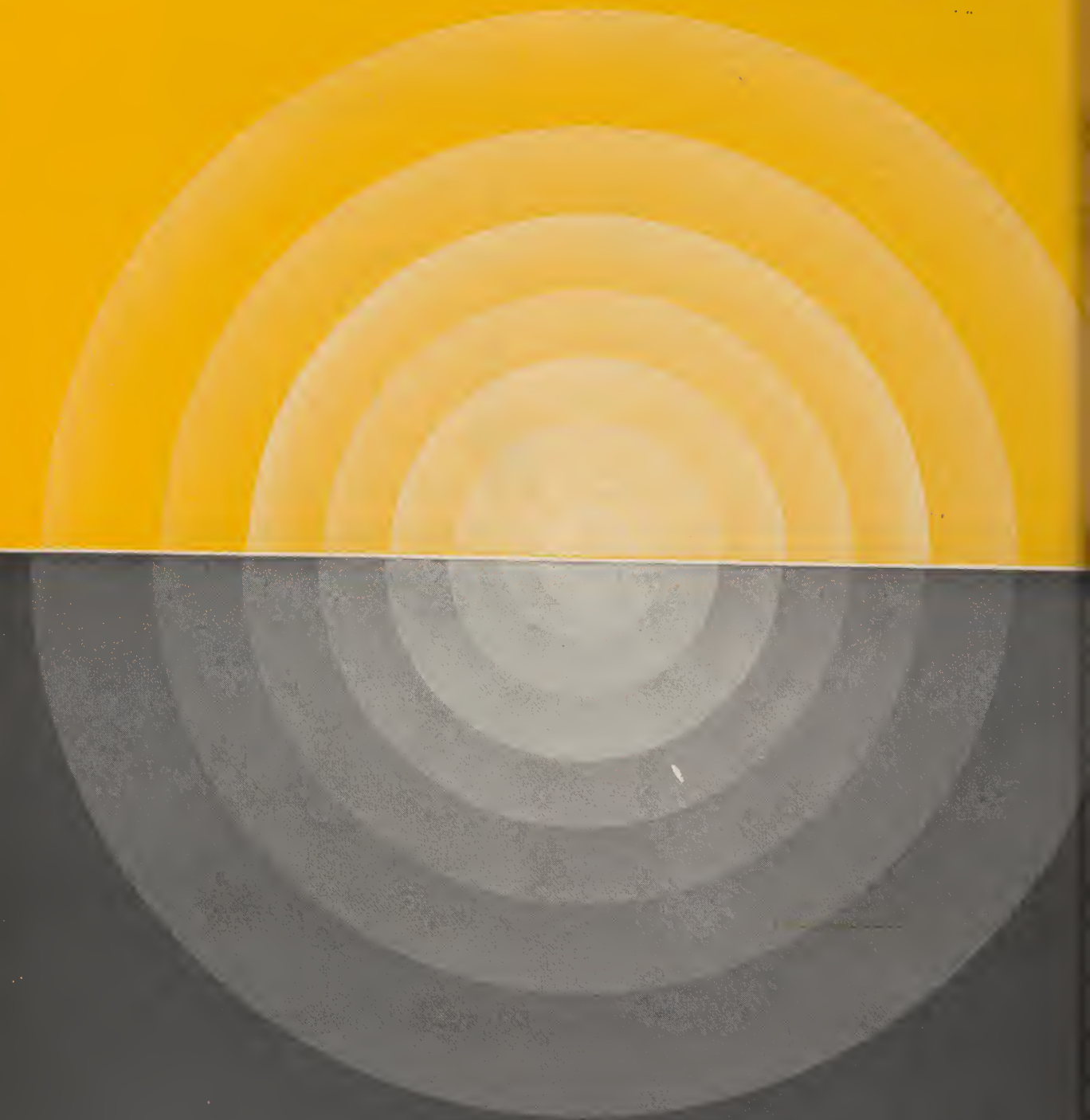
At the business session of the October meeting, an amendment to the by-laws was approved which granted Executive Committee membership to all Society members who hold office or are members of the Council at the State level.

Further business included a report on the public speaking seminar presented in Salisbury in late September by Smith Kline & French Laboratories.

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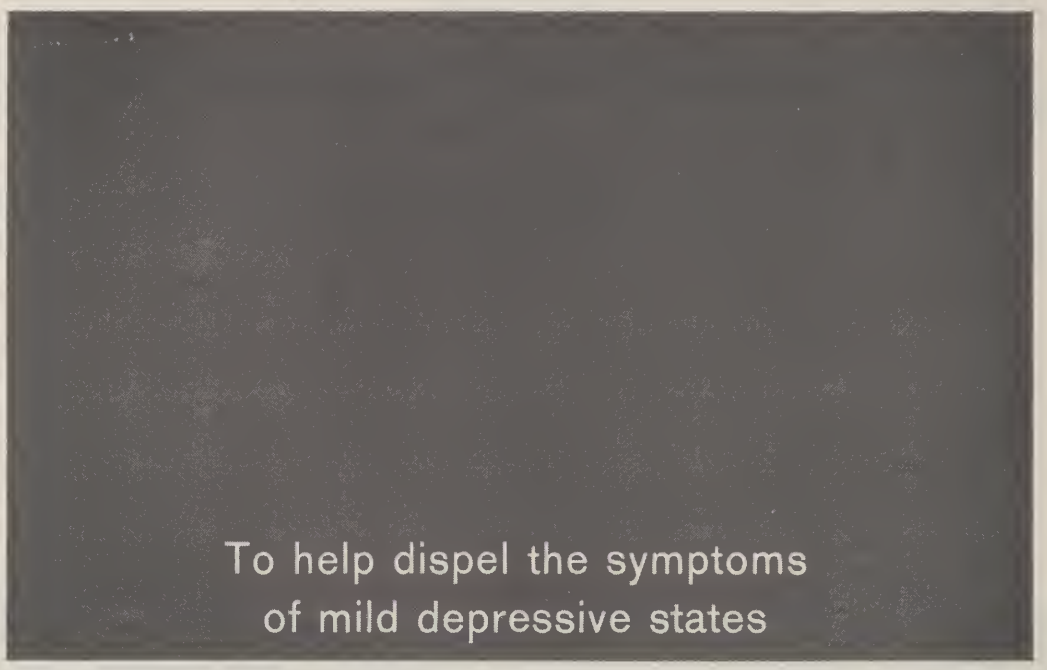
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Reference: 1. Raberts, C. E., Jr.; Perry, D. M.; Kuharic, H. A., and Kirby, W. M. M.: A. M. A. Arch. Int. Med. 107:204 (Feb.) 1961.

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Mode of Action of Antimicrobials

MOHSEN ZIAI, MD
Associate Professor of Pediatrics
The Johns Hopkins University School of Medicine

An antimicrobial agent is useful if it can interfere with metabolic reactions of the microorganism that do not exist in the host cells or, if they do, are not accessible by the drug. This phenomenon is known as selective toxicity. There are three possible sites for the effect of antimicrobials, although it is possible for an antimicrobial agent to act on more than one of them. These sites are:

1. The cell wall
2. The cytoplasmic membrane
3. The cytoplasmic metabolic processes

1. Interference with the Formation of Cell Wall

One of the fundamental ways that bacteria differ from animal cells is that each possesses a rigid cell wall which surrounds its cytoplasmic membrane. This cell wall is not to be confused with an additional covering, the capsule, present in certain bacteria.

It is possible to remove the bacterial cell wall. What is left of the bacterial cell is then known as a protoplast. The protoplasts (or L forms) differ functionally from normal bacterial cells in that they have lost their resistance against osmotic lysis, a function ordinarily provided by the rigid cell wall. If one provides a delicately balanced osmotic medium for the protoplasts, they will continue to survive and multiply.

Penicillin interferes with the formation of bacterial cell walls. It consequently produces a lethal effect upon bacteria by making them susceptible to osmotic lysis. This action is exerted on the gram negative as well as the gram positive bacteria, although to a lesser degree. If bacteria are kept from multiplying, penicillin will have no effect on them. Resistance to penicillin is due to the production of penicillinase, which destroys penicillin, although certain mutants are found that are not penicillinase producers, but are nevertheless resistant to the action of this drug.

Novobiocin and bacitracin also act at this site, ie, on the cell wall.

2. Damage to the Cytoplasmic Membrane

The cytoplasmic membrane has an extremely important role in the life of the bacterial cell. It acts as a barrier which regulates the movement of various substances to and from the surrounding medium, thus controlling the permeability of the cell. It makes it possible for the bacterial cell to maintain far greater concentrations of certain metabolites, such as sugars and amino acids, within itself: this phenomenon produces a very high osmotic pressure. Important metabolic lesions can be produced on the bacteria by any damage to the cytoplasmic membrane. Examples of this mode of action are polymyxin, colistin, and streptomycin.

3. Interference with Cytoplasmic Metabolic Processes

Several cytoplasmic metabolic processes of bacteria can be deranged by antimicrobials. Some of these are only of academic interest and provide a method for studying normal cell physiology. Others are of practical importance in the treatment of infectious diseases. These are as follows:

a. Inhibition of Protein Synthesis

Chloramphenicol is the most extensively studied member of this group, although other antibiotics, eg, tetracyclines, erythromycin and streptomycin, also act in this general manner. Their exact mode of action is, however, different. Chloramphenicol is thought to work at the ribosomal phase of protein synthesis, ie, preventing the normal attachment of genetic messenger RNA to ribosomes.

b. Metabolic Analogues

Sulfonamides were the first group of substances to be used as effective antibacterial drugs. These compounds are structurally similar to para-aminobenzoic acid (PABA), which is essential as a building block in the synthesis of folic acid by certain bacteria. This structural similarity produces confusion. Using the sulfonamides instead of PABA therefore prevents the multiplication of these pathogens. This mechanism of drug action is known as competitive inhibition. If the amount of PABA is increased, or the drug decreased, the quantitative effect will no longer be adequate. Such is the case in abscess cavities where tissue destruction leads to excess availability of PABA.

The mode of action of para-amino salicylic acid (PAS) is also through this mechanism. (See Figure).

Antimicrobial Therapy of Non-bacterial Infections

1. Viruses and Rickettsia

One would expect no selective antimicrobial drug action against viruses and Rickettsia as these are obligate intercellular parasites. In clinical practice, however, this is not the case.

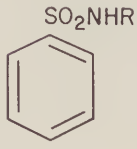
Rickettsial infections respond to tetracyclines and chloramphenicol, thus indicating that these drugs can penetrate into the host cells and selectively destroy the pathogen. Similar observations can be made with regard to certain virus infections such as trachoma, lymphogranuloma venereum and primary styptical pneumonia.

2. Protozoa

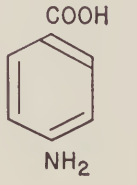
The mode of action of drugs against this group of pathogens is varied. Antitrypanosomal agents, for example, act through interference with nucleic acid synthesis in these organisms. In case of some other pathogens, such as E. histolytica, the drugs may act primarily on the host, making the environment that he provides for the parasite less favorable.

3. Fungi

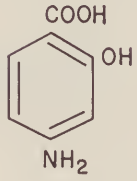
Antifungal drugs generally act on the cytoplasmic membrane.



Sulfonamides



PABA (Para-Aminobenzoic Acid)



PAS (Para-Aminosolicylic Acid)

Summary

It is apparent from the foregoing discussion that antibiotics differ altogether from certain other compounds such as antiseptics in their method of destroying the disease-producing organisms. A comprehension of the mechanisms involved in the interplay between the drug and parasite is important in taking an intelligent approach to chemotherapy of infections.

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REHABILITATION Notes

REHABILITATION SECTION
BALTIMORE CITY MEDICAL SOCIETY,

DOUGLAS G. CARROLL M.D.
EDITOR

Exercise Tests in Heart Disease

DOUGLAS G. CARROLL, MD
Chief, Physical Medicine and Rehabilitation
Baltimore City Hospitals

"Thus use of exercise in clinical practice is the most neglected sector of medical therapy."[1]

Exercise tests have a number of potential uses in clinical medicine. If there were a simple, reproducible and reliable test it could be used in the office or at the bedside to estimate cardiac performance. Unfortunately, however, there is no such test.

Existing exercise tests may be used in difficult cases to obtain an objective measurement of performance, particularly in evaluation for operation. They may also be used to estimate energy expenditure in certain jobs to determine whether the latter can be safely performed by patients with heart diseases.[2, 3]

Newman[4] has outlined an exercise program for bed patients following acute myocardial infarction. These exercises could be used to measure exercise tolerance during the acute stage of heart disease, but most exercise tests are performed after recovery from myocardial infarction or when cardiac compensation is established.

If a simple exercise tolerance test (such as walking up a flight of stairs) is administered carefully and used with the history and physical examination, it is estimated that, in 65% of the more difficult cases referred to a Work Evaluation Unit, the physician can give an accurate evaluation of what the patient can perform safely.[5]

STEP TESTS

Angina pectoris and shortness of breath are two symptoms warning that cardiac reserve is being overtaxed. The following are some of the standardized step tests which are useful in estimating exercise tolerance and which may be applied to patients with heart disease:

1. The Schneider Test

In the early 1920's, Schneider[6, 7] described an exercise test useful to estimate "physical fitness" in army recruits. The test consisted of taking control pulse rates with the subject recumbent, standing and reclining. The subject then exercised by stepping up five 10½ inch steps in 15 seconds. Following the exercise, the time required for the pulse to return to normal was recorded. A large number of presumably normal inductees were tested by this procedure and standards were derived. Unfortunately, a number of factors other than exercise tolerance affected the pulse rate, the test took too long to perform, and it was not standardized on cardiac patients.

2. Master's Two-Step Test

Initially developed as an exercise tolerance test[8] or test of myocardial function,[9] the Mas-

ter Two-Step Test is now widely used as a standard stress test to elicit electrocardiographic changes associated with insufficiency of coronary blood supply.[10] The original amount of stress was standardized on normal people of varying weights and ages, to conform with a standard return of pulse rate and blood pressure to the resting level within two minutes of the end of exercise. Ford and Hellerstein[11] have shown that the test requires an oxygen consumption of about 6.8 times resting oxygen consumption. This is not a steady state type of exercise, and resembles most of the tasks performed in ordinary housekeeping or on the job. The amount of work is equal to that of stair climbing and is greater than the peak requirement of most non-laboring work. The Master's Two-Step Test was shown[11] to impose equal energy demands on patients of different ages and weights and to be safe for patients with stable heart disease if done under careful supervision. The authors conclude that the physiologic and electrocardiographic response to the Master's Test can provide a sound basis for counseling in regard to activities both at work and in ordinary daily activities. This is the best standardized exercise test for patients with heart disease and is adequate for evaluation of exercise tolerance.

3. Harvard Fatigue Laboratory Step Test[12]

This test has not been extensively used on patients with heart disease, probably because it is too vigorous. The scoring has been standardized on normal young volunteers. It attempts to measure "physical fitness." It is dependent on pulse rate taken one minute after a standardized step exercise. Its advantage is that a number can be obtained which relates pulse response to normal values.

4. Baldwin, Cournand and Richard's Step Test

This test[13] has been well standardized on normals and extensively used in patients with respiratory diseases. It is easy enough to be

	MEASUREMENT								
Test	ECG	Pulse Rate	BP	VE	VO_2	FaO_2	Resp Rate	FIO_2-FEO_2	
Master[10]	B R	R							Step Test
Harvard[12]		R							Step Test
Cournand[13]		R		B E R	B E R	B R	B R	B E R	Step Test
Los Angeles[11]	B E R	R	B E R						Step Test
Bruce PFI[15]	B E R	R					E		Step Test
Bruce PFI	B E R	B E R	B E R						Treadmill

Table 1
Comparison of Information Collected in Various Tests of Exercise Tolerance

B = Measurement made at rest
E = Measurement made during exercise
R = Measurement made during recovery period

performed by patients who are short of breath, since it requires only 30 steps up and down a 20 cm step in one minute. Oxygen consumption, ventilation and pulse rate are measured at rest, during the exercise, and for each minute of the five-minute recovery period. In addition, the arterial blood saturation is determined immediately after exercise, and the degree of dyspnea and ventilation during recovery are related to the maximal breathing capacity. The test measures ventilation and respiratory insufficiency, but could be modified for use in patients with heart diseases.

5. Los Angeles Work Classification Unit Exercise Tolerance Test[14]

This test lasts for ten minutes, with 20 steps per minute up an eight-to-nine-inch step. Pulse rate, blood pressure, electrocardiography, signs and symptoms are recorded during exercise and/or for three minutes after exercise.

The energy required for the test is four to five times basal level and is carried on for a longer period than the other tests.

6. Physical Fitness Index (Step-test method)

Bruce[15] has described a step test at 20 times per minute for 10 minutes in which the average respiratory rate per minute of exercise and the cumulative heart rate for the first three minutes of recovery are measured. Physical Fitness Index (step-test) $= \frac{E\ (k^1)}{(r^1)\ (c)} \times \frac{S}{20}$ where E is time of exercise (10 minutes), k^1 is 10,000, r^1 is average respiratory rate during exercise, c is cumulative heart rate during first three minutes of recovery. S is the number of steps per minute. This test has the advantage of requiring no complicated equipment and of giving a number which may be compared to normal values.

Step tests are simple, are safe if performed under supervison by a physician, and give the information needed to prescribe amount of exercise. All except the Harvard Fatigue Laboratory Step Test require interpretation of the findings and the symptoms by a physician. The Harvard test has not been widely applied to patients with heart disease, but has the possible advantage of allowing quantitative comparisons with normals and other patients. Whether so complex an activity as exercise tolerance in a patient with heart disease can be quantitated in a significant manner remains to be seen.

Since most ordinary daily work consists of intermittent non-steady state exercise with peaks of energy expenditure, non-steady state exercises may be more valuable for predicting safe exertion than the steady state tests.

TREADMILL TESTS

Although treadmills are somewhat more expensive and unwieldy than steps, they are preferable for precise work. Skill and training factors are not as important on the treadmill and the patient does not have to keep time in stepping. Following are two treadmill tests:

1. The Physical Fitness Index (Treadmill Method)

Over a number of years Bruce[16] has been attempting to standardize a test for physical fitness which may be applied to patients with heart disease. The test requires 10 minutes of walking on a treadmill at a 10% grade at 1.7 mph. Signs and symptoms, electrocardiogram, pulse, blood pressure and oxygen consumption are determined during exercise and during three minutes of recovery. The Physical Fitness Index $= \frac{(E)\,(r)\,(100)}{C}$ where E is the duration of exercise (usually 10 minutes), r is average difference between inspired and expired oxygen percent during exercise ($FIO_2 - FEO_2$) and C is the cumulative heart rate for the first three minutes of recovery. A normal PFI is from 13 to 26.

Class III and IV cardiac patients generally cannot complete the full 10 minutes. Class II patients can generally complete the exercise, but may have some dyspnea of moderate intensity. Class I patients usually show slight, if any, symptoms. Electrocardiographic changes are frequent in Classes III and IV. The actual time the patient can walk on the treadmill is the most important measurement. Completion of the test without severe dyspnea requires energy equivalent to ordinary laboring work in industry.

2. Estimation of maximal oxygen consumption

If it were possible to determine easily, the measurement that would be most helpful in estimating work potential would be maximal oxygen consumption in a steady state. This

measurement is directly related to maximal energy expenditure and maximal cardiovascular function in normals[17, 18] as well as in patients with heart disease.[19] Methods have been perfected for this determination in normal men on treadmills,[20] but it has been difficult to perform this test in patients with heart disease because maximal exertion is considered dangerous.

Since a number of variables besides oxygen consumption increase during exercise, it might be possible to take several levels of mild exertion and predict maximal oxygen consumption in patients with heart disease. This prediction has been attempted in a limited number of healthy young men,[20] but the results have not been completely reported.

Wyndham and Ward[21] have attempted to estimate maximal oxygen intake in patients with heart disease by measuring pulse rate and oxygen consumption a low work levels, and extrapolating to a pulse rate of about 200 per minute, with the assumption that oxygen consumption is maximal at this heart rate.

Another approach would be to predict maximal minute ventilation from the maximal breathing capacity performed at rest. Dripps and Comroe[22] have reported a mean expiratory minute volume at peak oxygen consumption of 66% of mean maximal breathing capacity in normal men from 21 to 26 years of age. Slonim, Gillespie and Harold[20] give a value of 83% of mean maximal breathing capacity as the point of peak oxygen consumption for their normal subjects. Whether these figures are applicable to patients with heart disease is not yet known.

Functional Classification	Approximate Allowable Maximal Calories/Minute Expenditure in Non-Steady State Exertion	Activities of Intermittent Nature in Order of Descending Exertion
I No Restriction of Ordinary Activities	4-6.6	Carrying up to 50 pounds, heavy carpentry, sawing soft wood, walking 3.75 mph, dancing, bedmaking, golfing, swimming (20 yds per min), wheel barrow (115 pounds at 2.5 mph), hanging wash, bowling, showering, mopping (standing), plastering, playing drums, vacuuming rug (4 ft/sec)
II Slight Restriction of Ordinary Activities	2.7 to 4	Making beds (not stripping linens), cleaning windows, scrubbing floors, walking 2.5 mph, using bed commode, dressing, washing, shaving, industrial finishing and lathe turning, volley ball, motor cycling, kneading dough, laboratory work, sheet metal work, slow horseback riding, canoeing 2.5 mph, washing small clothes, cobbling shoes, industrial machine sewing, driving car, factory assembly work, radio assembly, playing violin.
III Marked Restriction of Ordinary Activities	1 to 2.7	Washing and dressing, vacuuming rug (3 ft/sec), playing piano, light machine work (engineering), polishing furniture, wheelchair propulsion, recreational painting (standing), armature winding, wringing clothes by hand, playing cards, walking 1.1 mph, weaving (floor loom).
IV Severe Restriction of Physical Activities	1 Calorie/min.	Sitting or resting supine.

Table 2
Functional Classification of the American Heart Association and Caloric Cost of Certain Activities[23, 24]

SUMMARY

For at least 45 years physicians have been trying to develop a simple office test of exercise which will give a reliable measure of cardiac performance. Unfortunately such tests as have been designed require either too much time or expensive equipment. Until such a time as an ideal test is designed, that of walking the patient up a flight of stairs and observing his pulse and degree of dyspnea is usually adequate. Patients who need more precise testing for job placement or for surgical evaluation may be referred to the Work Classification Unit of the Maryland Heart Association or to a hospital exercise physiology laboratory.

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MOLECULAR REMODELING—

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More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

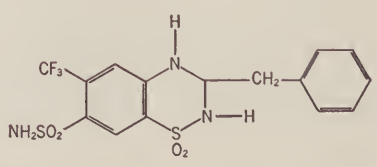
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin ĉ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (50 mg.)]. For full information, see Product Brief.

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Warnings—Medication should be discontinued pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. Medication should be withdrawn if examination reveals papilledema or retinovascular lesions. Since the safety of Ovulen therapy in pregnancy has not yet been established, it is recommended that, in a patient who has missed two consecutive menstrual periods, pregnancy be ruled out before oral contraceptive therapy is continued.

Precautions—Because Ovulen may aggravate a tendency toward fluid retention in some patients, it should be administered cautiously to patients with a history of renal or cardiovascular disease (including hypertension), asthma, epilepsy or migraine. Any possible influence of long-term Ovulen therapy on pituitary, adrenal cortical, ovarian, hepatic or uterine functions requires further study. Oral contraceptives also should be administered cautiously to diabetic patients since a decrease in glucose tolerance has been observed in some patients taking these drugs. Patients on Ovulen may occasionally show abnormal glucose tolerance tests, but this does not necessarily indicate the presence of diabetes. Significant increases in platelet count, prothrombin and proconvertin tests, plasma thrombotic activity and plasma proteolytic activity have been reported.

Since estrogens may affect results of serum protein bound iodine and other thyroid function tests, these tests should not be considered definitive until Ovulen therapy has been discontinued for at least sixty days. Adrenal steroid serum levels and excretion may be affected by estrogens; the Metopirone® (SU-4885) test of pituitary-adrenal function may also be depressed. Abnormalities in hepatic function tests have also been reported, including some interference with dye excretion by the liver. This interference may give rise to Bromsulphalein® retention and jaundice in susceptible individuals. Serious liver dysfunction should be ruled out before continuing Ovulen administration when abnormalities in liver function tests occur.

Patients with a history of psychic depression should be observed carefully during treatment with oral contraceptives, and such treatment should be discontinued if depression recurs to a serious degree. Pre-existing fibroids may increase in size during Ovulen therapy. Such fibroids may regress to pretreatment size after Ovulen is stopped. In the event of breakthrough bleeding the possibility of nonfunctional causes should be borne in mind. Additional means of contraception should be used during the first seven days of Ovulen administration in the first treated cycle, because early ovulation may possibly occur.

Side Actions—The following adverse reactions have been reported with Ovulen; however, a causal relationship to Ovulen administration has not been established in all of the listed complaints: headache, dizziness, depression, breast complaints, amenorrhea, chloasma, vomiting, allergy, edema, migraine, pulmonary embolism, thrombophlebitis, visual difficulties, nervousness, rash, itching, decrease in libido, tiredness, malaise, hair loss and hair growth. A small incidence of nausea, spotting and breakthrough bleeding has been reported; these complaints tend to diminish markedly or disappear after the first cycle of treatment. Some of these side actions have required discontinuance of the drug.

Dosage—One tablet daily for 20 consecutive days beginning 5 days after the onset of menstruation.

Before prescribing see Detailed Product Information, Ovulen.

An extensive list of references on Ovulen is included in the literature mailed to physicians.

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ontraindication — History of hypersensitivity to demethyl-hlortetracycline.

Warning — In renal impairment, usual doses may lead to xcessive systemic accumulation and liver toxicity. Under uch conditions, lower than usual doses are indicated nd, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or rtificial sunlight has been observed. Small amounts of rug and short exposure may produce an exaggerated unburn reaction which may range from erythema to evere skin manifestations. In a smaller proportion, pho-oallergic reactions have been reported. Patients should void direct exposure to sunlight and discontinue drug at he first evidence of skin discomfort.

Precautions and Side Effects — Overgrowth of nonsuscep-ible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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the HEART PAGE

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Kenneth B. Lewis, MD—*Editor*

CONSTRICTIVE PERICARDITIS

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Constrictive pericarditis is an uncommon disorder and frequently difficult to diagnose. In the patient with a small quiet heart, high venous pressure, pulsus paradoxus, ascites, edema and calcium in the pericardium, constrictive pericarditis is easily diagnosed. In our experience, however, this textbook description of constrictive pericarditis is rarely encountered.

Because the disease results in considerable disability and mortality, and because surgical therapy is effective, it is important to establish the diagnosis, but despite the presence of good clues, it is easily overlooked.

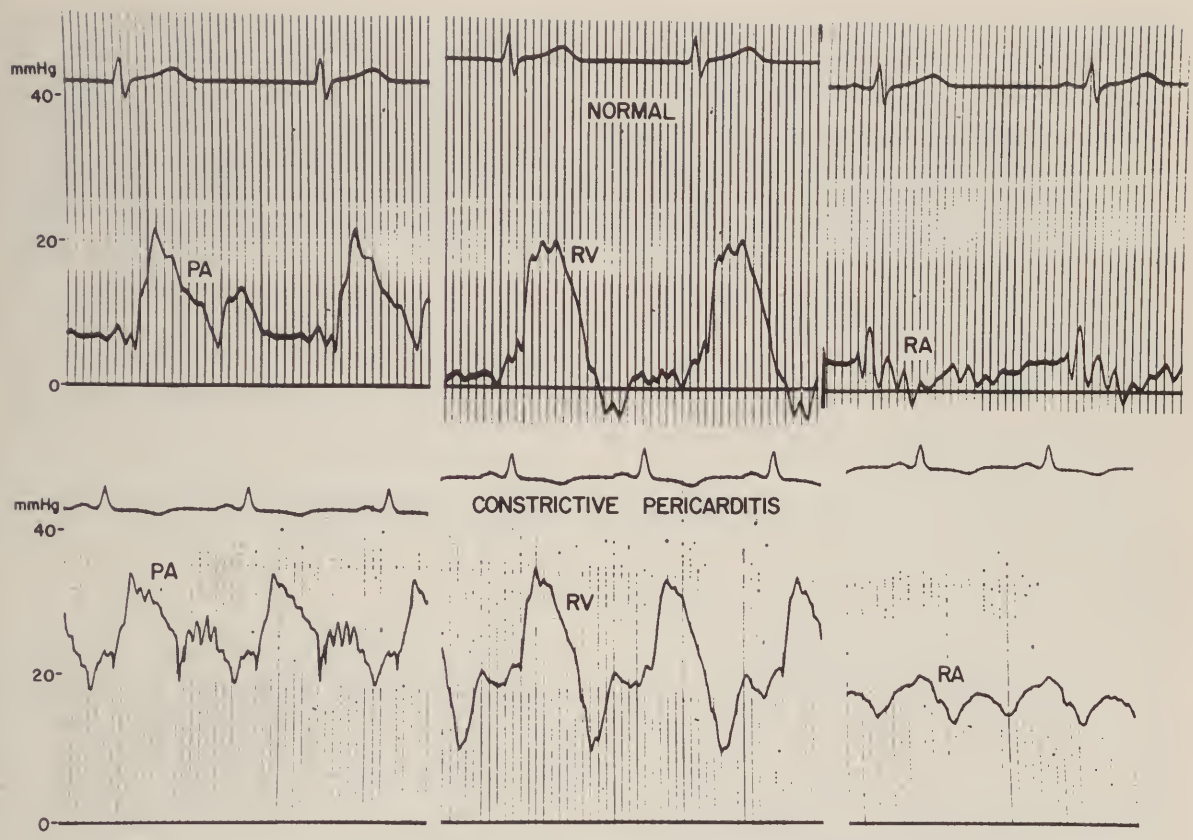
The jugular venous pressure is raised in constrictive pericarditis because diastolic filling of the ventricle is hampered. Elevated venous pressure is, therefore, the most consistent physical finding in constrictive pericarditis. The pathologic anatomy of constrictive pericarditis adequately explains these physiologic derangements, ie, fibrous tissue encases the heart and limits diastolic expansion of the ventricles resulting in an inadequate cardiac filling at a markedly elevated filling pressure. The ventricular pressure pulse characteristically exhibits an initial early diastolic dip followed by a plateau throughout the remainder of diastole (see Figure).

On auscultation, an early protodiastolic sound, known as a pericardial knock, is frequently heard in constrictive pericarditis. This sound is produced by the abrupt halt in filling, early in diastole, and coincides with the sudden upswing of the ventricular pressure to its diastolic plateau (see Figure).

Problems in diagnosis arise for the following reasons: (1) the diagnosis is not considered, (2) primary manifestations of constrictive pericarditis are obscured by secondary symptoms and physical findings simulating other diseases, and (3) the presence of other cardiac disease may obscure the fact that constrictive pericarditis is also present. The following case summaries will serve to illustrate some of the pitfalls one encounters with constrictive pericarditis.

1. Diagnosis not considered

A 31-year-old physician's wife was seen with a seven-month history of ascites and ankle edema. She had consulted several physicians and had received a variety of treatments prior to her admission to the hospital for evaluation. On the admission examination, she had ascites, hepatomegaly and edema. In addition, venous pressure was elevated and an apical third heart sound



Intravascular pressure tracings in a normal patient (upper) and a patient with constrictive pericarditis (lower).

The lower tracings demonstrate the inability of the ventricle to expand properly; the ventricles are filled to their limit very quickly (diastolic dip), resulting in a rapid rise of the ventricular pressure (diastolic plateau), which in turn elevates the atrial and venous pressures.

was present. The differential diagnosis during the early portion of the examination included inferior vena caval obstruction, primary liver disease, hypothyroidism, chronic renal disease, intra-abdominal neoplasm with lymph node compression and lymphoma. Initially cardiac disease was not considered. Persistence of elevated venous pressure following diuresis prompted strong consideration of constrictive pericarditis. Successful pericardiectomy was performed.

This patient demonstrates the fact that a wide variety of diseases may be confused with constrictive pericarditis, despite the fact that all facets of the clinical history are well explained by the presence of constriction.

2. Primary manifestations of constriction obscured by secondary symptoms and physical findings

A 27-year-old Lebanese bank clerk was felt to have had acute rheumatic fever and was considered for a twelve-year period to have rheumatic heart disease. During the three years prior to admission, he developed congestive heart failure and obtained only partial relief with usual therapeutic measures. At the time of admission to our hospital, he presented as quite an obese man with atrial fibrillation, elevated jugular venous pressure and an early diastolic adventitious sound, hepatomegaly and ankle edema. It was felt his atrial fibrillation and early diastolic sound (the pericardial knock) were explicable on the basis of constrictive pericarditis and that no valvular disease was present. At catheterization, this proved to be correct and he successfully underwent pericardiectomy. Repeat catheterization one year following pericardiectomy revealed some restrictive abnormalities of the heart although he was markedly improved.

This patient demonstrates the confusion that can arise on the basis of the physical findings. In this instance, the pericardial knock was felt to be

the opening snap of mitral stenosis and the atrial fibrillation was thought to be secondary to his rheumatic heart disease. A large percentage of individuals with constrictive pericarditis develop atrial fibrillation if the disease is untreated for a long period of time. This is due to the fact that the sinus node is directly involved by the pathology in the pericardium. In addition, myocardial atrophy, or at least some degree of myocardial dysfunction, may persist after successful pericardiectomy if the constriction has been present for a long period of time.

3. Other cardiac disease obscuring the presence of constrictive pericarditis

A 25-year-old male construction worker with a heart murmur from infancy was admitted to the hospital when he developed pneumonia and was found to have cardiomegaly and congestive failure. On physical examination, he had right ventricular hypertrophy and auscultatory findings of atrial septal defect. Hepatomegaly and ascites were also present. His congestive failure proved extremely refractory to all varieties of treatment. Cardiac catheterization confirmed the clinical suspicion that an atrial septal defect was present. In addition, there was marked elevation of diastolic pressures throughout the heart, a most uncommon hemodynamic finding for an atrial septal defect. Even after this catheterization, constrictive pericarditis was not considered to be present. Following a prolonged period of hospitilization and continuing congestive failure, however, a thoracotomy was undertaken, constriction was found to be present and, following relief of constriction, the patient has been totally asymptomatic despite the fact that the atrial septal defect persists.

This patient demonstrates the fact that the presence of other cardiac disease may make it extremely difficult to think of and diagnose constrictive pericarditis even though the constrictive pericarditis is presenting the major hemodynamic burden to proper cardiac function. There is no definite relationship between congenital heart disease such as atrial septal defect and constrictive pericarditis, but in this case the two were associated and the constriction was by far the most important insofar as clinical symptomatology is concerned.

* * * *

We have seen other patients presenting difficult diagnostic problems, (1) rheumatic heart disease with mitral stenosis and associated constrictive pericarditis, (2) constrictive pericarditis presenting as protein-losing enteropathy, and (3) localized constrictive pericarditis masquerading as pericardial tumor with tricuspid obstruction. In every instance, however, carefully considering the diagnosis of constrictive pericarditis in individuals who have elevated venous pressure without readily evident cause, greatly facilitates one's ability to establish the diagnosis promptly.

Constrictive pericarditis is a disease of multiple etiology and in review of eleven proven cases we have seen recently, we were able to establish an etiology in none of them. Tuberculosis was formerly a cause in 20% to 25% of the cases. Histoplasmosis and other varieties of granulomous diseases account for some cases of constriction. Trauma, probably viral pericarditis, and a variety of other etiologies may result in constriction after a long period following the original insult.

Pericardiectomy is an extremely effective treatment for constrictive pericarditis and with current surgical techniques carries a very low mortality. The key to successful surgical therapy is early intervention, prior to the time that secondary myocardial changes have occurred or before irreversible changes are present in the liver from longstanding severe venous congestion. Proper interpretation of cardiac findings, careful determination of venous pressure, and continued search until these findings are satisfactorily explained, will lead to the diagnosis of this uncommon but interesting and important disorder.

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Alcoholism
SECTION

From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Sedation of Alcoholics with Non-depressing Compounds

JOSEPH THIMANN, MD
Medical Director
Washingtonian Hospital, Boston

It is a well-known fact that addictive (and that means also excessive) drinkers, when admitted to a hospital at the end of a drinking spree, suffer from marked tension, restlessness, apprehension, and feelings of guilt. For these reasons, they have a great need for sedatives, hypnotics and other tranquilizers, all depressants of the central nervous system.

Unfortunately, alcoholic beverages, especially in excessive amounts, are depressants of the central nervous system also. Thus, the medications desired by the patients are bound to increase the already existing depression of the central nervous system to a sometimes serious extent.

All this was the reason that, for many years, physicians dealing with acutely intoxicated patients have aimed at reducing their need for depressants by the use of various non-depressing therapeutics and procedures. Such an agent was a combination of a sympathetic and parasympathetic depressant, such as bellafoline-gynergen[1] combination, without any outright sedative drug. Another such therapeutic procedure in this line was a subshock dose of insulin[2] followed by glucose and thiamine.

More recently, another attempt was made to keep the depression of the central nervous system as moderate as possible by applying monosodium l-glutamate* without any other chemical compounds or, if necessary, combined with *moderate* amounts of hypnotics, sedatives or tranquilizers in withdrawal phase of acute alcoholism.

Material

The pharmaceutic material and its method of action have been described very adequately by H. Waelsh[3]: "L-Glutavite is a nutritive supplement and consists of a fine, yellowish granular powder containing the ingredients monosodium l-glutamate plus vitamins of the B group and iron.

"It is presumed that the glutamate, after absorption, appears in the blood stream as glutamic acid and that it is the main ingredient affecting cerebral metabolism. Its participation in the Krebs cycle and carbohydrate metabolism constitutes the main source of metabolic energy for nervous tissue. The vitamins plus iron may contribute toward correcting nutritional deficiencies that frequently are found in alcoholics. Extensive studies of glutamic acid-glutamine metabolism on brain physiology reveal the importance of these amino acids and their derivatives on the functioning of the nervous system."

(*continued*)

This article first appeared in the Special Report series of the North American Association of Alcoholism Programs, August 1966. Reprinted by permission.

*L-Glutavite (Crookes-Barnes Laboratories, Inc.)

Method of Study

This study encompassed 100 patients admitted in the state of acute intoxication. All 100 patients were white. Of these, 50 served as the experimental group, the other 50 as a control group. In the experimental group, there were 36 male and 14 female patients; the ages ranged from 24 to 72 years; 25 patients were first admissions, 25 were repeaters. The average length of hospitalization was seven days. Each patient received a teaspoonful of monosodium l-glutamate three times a day, admixed with tomato juice or soup.

Of the 50 experimental patients, one refused to take monosodium l-glutamate after a one-day application. Of the remaining 49 experimental patients, eight required no additional medication except dilantin and vitamins. Their response to monosodium l-glutamate alone was, both subjectively and objectively, very gratifying.

The remainder of 41 experimental patients required additional tranquilizers such as promazine, and hypnotics such as paraldehyde or veronal. In this group treated with a combination of monosodium l-glutamate, hypnotics and sedatives, three patients developed side effects (nausea and dizziness, rash, muscular spasms). In these three patients monosodium l-glutamate was discontinued. A total of 33 patients showed marked to complete recovery, nine patients showed moderate improvement. In one case, the patient's cardiac condition clouded the therapeutic effect; in another case, concurrent drug addiction made it difficult to judge the reduction of the alcoholic withdrawal symptoms.

In the control group, there were 36 male and 14 female patients. The ages ranged from 27 to 72 years; 18 patients were first admissions, 32 were repeaters. The average length of hospitalization was seven days. In the control group, medication consisted of promazine, diazepoxide, paraldehyde, veronal, dilantin and vitamins. Of these patients, 27 showed marked to complete recovery; 15 patients responded moderately to the medication; five patients showed mild or no alleviation of their withdrawal symptoms; three patients left the hospital after only three days of hospitalization.

One of these case histories will illustrate the favorable reaction to monosodium l-glutamate:

M.T., a 58-year-old widow, white, professional person, was admitted May 13, 1965. It was her second admission to the hospital, after a six-day spree of excessive drinking preceded by a feeling of loneliness. Patient appeared to be moderately intoxicated ("I am much more intoxicated than I look"). No gross impairment of gait and speech, however, was observed; patient displayed a marked state of tremors and anxiety. There was a history of poor food intake during the last three days prior to admission, and of poor sleep; no history of hallucinations, convulsive seizures or any psychosis. Patient was oriented in all three spheres and cooperative. Shortly after admission, the patient received seven grams monosodium l-glutamate t.i.d., dilantin and vitamin B; shortly thereafter, patient was offered a regular dinner, ate with reasonable appetite and kept it down. During the first night, the patient slept spasmodically, but with no tremors noted. From the second day on, the anxiety subsided steadily, food intake continued to be adequate, insomnia decreased gradually, no rash or any other side effect was observed. Seven days after admission, at the time of discharge, the patient showed a most adequate recovery with no evidence of any anxiety, tremors or insomnia.

Conclusions

Monosodium l-glutamate appears to be a useful drug in the management of the alcoholic patient. It shortened the duration of the treatment with paraldehyde and other sedatives and thus hastened the recovery.

The efficacy of the monosodium l-glutamate as a method of reducing or possibly eliminating the need for alcohol would be revealed in a future, more prolonged study if the application of this compound would be continued for a period of, at least, six months after the termination of the hospitalization, with regular check-ups on an outpatient basis.

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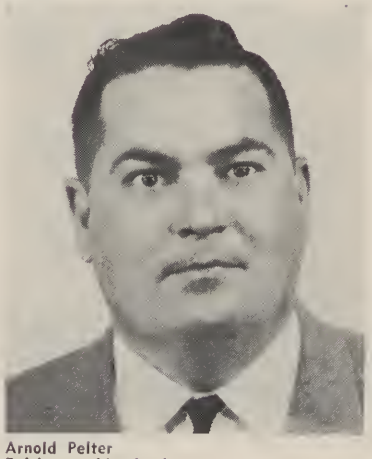
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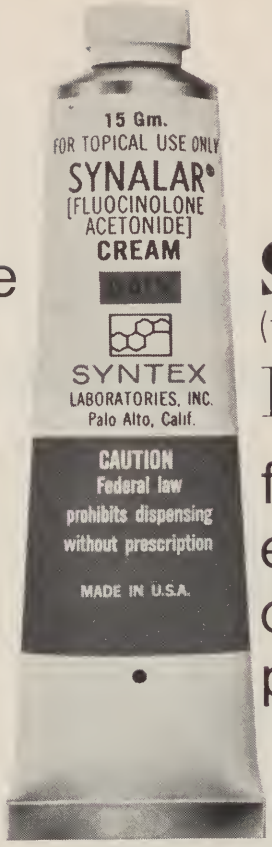
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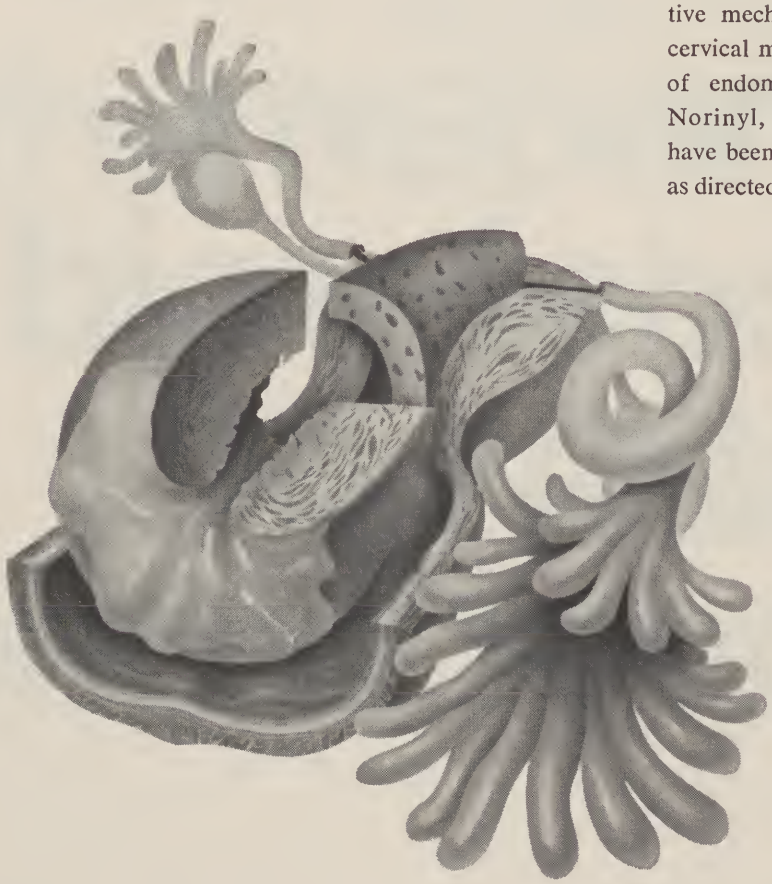
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Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

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Planting Seeds of Concern for Retarded

Doctors fighting public misunderstanding of mental retardation can now count on the help of some 700 high school, college, and graduate students throughout the country. The young men and women have just completed a summer of work with retardates in 49 institutions.

The 700 were selected from thousands of applicants to participate in a government program designed to interest the cream of American youth in the field of mental retardation as a career. Project SWEAT—Student Work Experience And Training—was launched this year by the Department of Health, Education, and Welfare with grants to participating institutions.

"The very least such a program can do is create a greater understanding of mental retardation in hundreds of communities from coast to coast," says Dr. Robert I. Jaslow of the Public Health Service. "This summer we had students getting that understanding firsthand, and they will be able to pass it along to others." Dr. Jaslow is chief of the Mental Retardation Branch of the PHS Division of Chronic Diseases.

Seen As Human Beings First

Results of the program in terms of student entry into the mental retardation field remain to be assessed. But the 700 for the most part saw their summer charges as human beings first and retardates second—as men and women, boys and girls, not as some mutated species to be hidden away from the national conscience.

"I was surprised at the sharpness of the youngsters," says University of Arizona coed Becky Gorrell, 18. She spent the summer with retarded children at the E. R. Johnstone Training and Research Center, Bordentown, N.J. "One day one of them asked me if I thought I could make it there," Becky recalls. "It took a few moments to realize I was being kidded."

Population of the 300-acre state-supported center along the Delaware below Trenton is 450 youths from 12 to 21 years of age.

The ten students at Johnstone were paid $1.38 to $1.88 an hour under a $12,000 grant that also covered other expenses incidental to their 8- to 12-week stay. Experience at the 49 participating institutions ranged from cottage and camp counseling to clinical and court commitment studies.

Dr. Joseph J. Parnicky, Johnstone superintendent, believes with Dr. Jaslow in the future of the project developed from a 1965 pilot program. "Even if some of the young people in SWEAT don't later become actively involved with mental retardation," Dr. Parnicky says, "we will receive indirect benefits from them and direct benefits from those who stick with it."

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DEPARTMENT OF HEALTH
STATE OF MARYLAND
William J. Peeples, MD, MPH, Commissioner

Highlights

Speed Up Medical Assistance Payments

With the seven-week backlog of bills accumulated while official notification of Federal approval of the State's Title XIX plan was pending, action to speed up payments became imperative. Through an arrangement with the Comptroller's office, advance payment of 75% of estimated accounts receivable is now being made on receipt of the request form sent to providers of service.

First Home Health Aide Class Graduated

The first group of Home Health Aides in Maryland was recently graduated after a two-week training program under the direction of Anne Arundel County's health officer, J. Howard Beard, MD. The students were employed during their training period, and will work under the supervision of public health nurses.

With the increased emphasis on home health services under Medicare and Medical Assistance programs, it is hoped that similar training programs will be established in other areas as needed.

The American Medical Association in 1960 urged physicians to "participate in organized home care programs for any patient who can benefit . . . and to promote such programs in their communities."

Laboratory Certification Temporarily Suspended

Further steps in certification of independent laboratories have been temporarily suspended, following word received from the Division of Medical Care Administration of the Public Health Service that major revisions are contemplated in "Conditions for Coverage of Services of Independent Laboratories" set forth by the Social Security Administration. The agency, which gives professional guidance to the Social Security Administration, states that organized opposition to certain provisions has necessitated the reconsideration. Interim certification to independent clinical laboratories has been completed to a considerable extent, and arrangements for payments to these laboratories are progressing.

It is believed likely that independent radiological laboratory facilities will not be subject to Medicare conditions.

State School Health Council Reorganized

In the recent reorganization of the Maryland State School Health Council, this advisory body's Executive Board, formerly limited to Departments of Health and Education personnel, was expanded to include local health officers and representatives of the Medical and Chirurgical Faculty of the State of Maryland, the Maryland Chapter of the American Academy of Pediatrics, the State of Maryland Department of Mental Hygiene, the Maryland Association of School Superintendents, the Maryland State Association for Higher Education, the Maryland Congress of Parents and Teachers, the Maryland State Nurses Association, the Department of Education, Archdiocese of Baltimore, and the Private Schools Association

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of Maryland. The Council itself consists of the Board and two representatives from each county and from Baltimore City, appointed by the local health officer and the local supervisor of schools.

The reorganized Council is expected to assume an active role in encouraging and helping to organize school health programs.

Three-Year Accreditation for Mt. Wilson

The accreditation of Mt. Wilson State Hospital by the Joint Commission on Accreditation of Hospitals for three years instead of the usual one reflects special credit not only upon the Chief of the Division of Respiratory Diseases and the Hospital Superintendent but also upon the entire hospital staff. Mt. Wilson's tradition of high-caliber service has been maintained in spite of personnel shortages and the need for adjusting to new demands and techniques.

Of the chronic disease-rehabilitation hospitals, Montebello passed its second inspection and is accredited for three years, Deer's Head passed its initial inspection and is accredited for one year, and Western Maryland is working toward accreditation.

The Department's voluntary participation in this program is part of its continuing effort to achieve excellence in its hospitals.

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Behavioral Study of Tuberculosis Patients

The National Tuberculosis Association has selected Baltimore as one of three locations in the United States in which to conduct studies on the behavioral characteristics of tuberculosis patients. Other locations from which data will be obtained from representative samples of the population are St. Louis and San Francisco.

The behavioral study in Baltimore City is planned to last for a period of three years, and will be locally administered by a behavioral scientist from the Johns Hopkins School of Hygiene and Public Health, who will appoint his own staff to work in the city chest clinics alongside of the city staff. The preliminary work is already under way and the main part of the study will start at the beginning of next year.

This study is being financed in part by the National Tuberculosis Association. Substantial assistance has been received from the Maryland Tuberculosis Association and from the Tuberculosis Association of the State of Delaware specifically for the Baltimore City project. The City Health Department is providing accommodations and will cooperate with the Study personnel in any way possible.

It is our hope that the study will help us remove all barriers between patients and clinics, reduce the present significant extent of noncooperation by tuberculosis sufferers, and thus accelerate the decline of tuberculosis in the city.

Robert E. Farber, MD
Commissioner of Health

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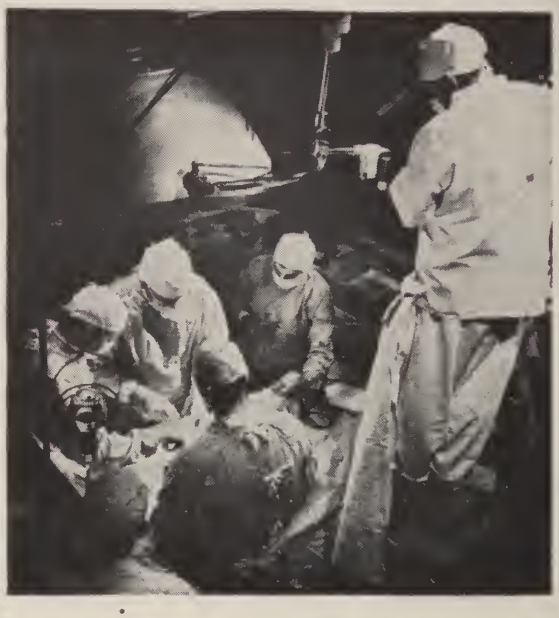
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The Mentally Retarded in Psychiatric Hospitals

Eight percent of the patient population in Maryland's psychiatric hospitals are classified as mentally retarded. These 621 compare with the 2,989 currently under treatment at Rosewood and Henryton, the Department's two hospitals for the mentally retarded. The following table shows their distribution by age and by length of hospitalization.

Length of Hospitalization	Total	Age (In Years) -15	15-24	25-34	35-44	45-54	55-64	65 and Over
Less than 1 year	81	7	28	17	14	7	4	4
1-4 years	110	1	22	28	25	13	15	6
5-9 years	41	—	4	10	15	6	6	—
10-19 years	135	—	3	24	39	26	24	19
20 years or more	254	—	—	11	30	58	84	71
Total	621	8	57	90	123	110	133	100
Median (years)	15.8	0.6	1.1	5.0	11.9	20+	20+	20+

The number of retarded patients in psychiatric hospitals has declined somewhat in recent years, mainly due to death and to the transfer of 15 to Henryton. As shown here, most have been under care for some time with a median continuous hospitalization in excess of 15 years. This is substantially higher than the comparable figure for all other patients. The number of discharged patients is small (an annual average of 138 during the last five years) and does not exceed the number of such new admissions. Releases have been mainly among recent admissions.

It should be recognized that mental disturbances in addition or related to retardation are quite common among those who are in psychiatric hospitals. They differ from the patients admitted to Rosewood in that most are adults who are classified as mentally retarded with psychosis. Also, they probably comprise a higher proportion of borderline retardates and a concomitant lower proportion of those below this level. Their relatively high median age on admission (29.5 years) indicates that hospitalization may have been caused by a change in the patient's condition or by death or other alteration in the family structure.

The psychiatric hospitals are acutely aware of



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the long-term retarded patients since these form a substantial proportion of their chronic population. Further efforts to reduce the size of this group are dependent on:

1. Additional construction in existing or planned hospitals for the retarded.
2. Stringent efforts to see that those whose primary reason for hospitalization is retardation are not admitted to psychiatric hospitals.
3. Expansion and coordination of nursing homes and other community facilities and resources.
4. Programs to assist families in maintaining retardates in their own homes.
5. Development of community-based small residential homes for the mentally retarded.
6. Expansion of sheltered workshop resources in the community.

MARYLAND ASSOCIATION OF MEDICAL ASSISTANTS

MAMA GOES TO ST. LOUIS

Members of the Maryland Association of Medical Assistants attended the recent AAMA convention in St. Louis, and there had the opportunity to hear an address by Charles L. Hudson, MD, President of the American Medical Association. Delegates to the convention from Maryland were Helen Wehmeyer, Wicomico chapter; Joyce Anderson, Alleghany-Garrett chapter; and Dorothy Hartel, trustee to AAMA, Baltimore chapter.

Betty Fern, president of MAMA, and Mabel Young, of the Alleghany-Garrett chapter, were also in attendance at the convention.

The Maryland delegates were pleased to receive three trophies at the convention as awards for percentage increase in memberships.

BALTIMORE CHAPTER HOLDS ELECTIONS

At the November meeting of the Baltimore Association of Medical Assistants, the following were elected for the 1967 term of office:

Eleanor Mainhardt, CMA,—president-elect
Dorothy Walker—vice-president
Arlene Whalen—secretary
William Leiby—treasurer

Past president-elect, Rita Cobry, will now begin her term as president of the association.

NEW ADVISOR APPOINTED TO BAMA

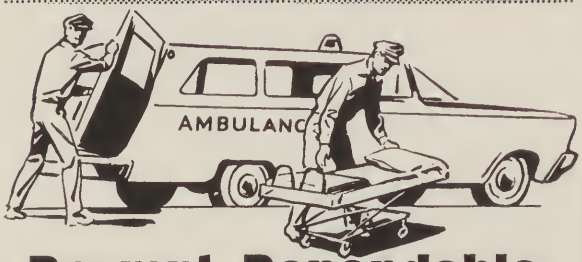
At the November meeting of the Baltimore Association of Medical Assistants, H. L. Wollenweber, MD, was elected to serve in an advisory position to the BAMA. John Littleton, MD who served as the organization's advisor for the past year with Edward Lewison, MD will continue as advisor with Dr. Wollenweber for the year.



H. L. Wollenweber, MD

MAMA MEMBER PASSES CERTIFICATION EXAMINATION

Eleanor Mainhardt, assistant to S. Elliott Harris, MD, recently passed the American Association of Medical Assistants' Certification Examination. This is quite an achievement for Eleanor since she is the first member of the Baltimore



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Association of Medical Assistants to become a CMA.

DR. GUNTER SCHULTZE SPEAKS TO BAMA

At a recent meeting of the Baltimore Association of Medical Assistants, Gunter Schultze, MD, radiologist, spoke on "X-rays, What They Are and What They Tell Us." His talk was enthusiastically received by the membership, and the slides which he showed were very educational.

Peggy Bury

Solutions to Business Problems in Daily Medical Practice



Annual Business Review

WILBURN L. McCLURE, JR.

Regardless of how many New Year's resolutions you may make or break, you might consider making one more: "I resolve to review every business phase of my medical practice at least once each year."

One good way of doing this is to use the following check list as a guide. You may wish to give a copy to the members of your staff for their review and coordinate your findings with theirs.

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Aides, Office
Answering Service
Appointments
Assistant Doctors
Automobile
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Billing Procedures
Budgeting Expenses
Business Methods
Cash Disbursements
Checkbook Routine
Collection Agencies
Collection Percentage
Collection Techniques
Community Activities
Consultants, Choosing
Consultants, Reports from
Conventions
Day Book Reporting
Depreciation
Drugs
Druggists, Choosing
Dues
Emergency Calls
Entertainment
Equipment
Estate Planning
Ethics
Expenses
Family (In office)
Fees
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Flow Plan
Forms
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Government Agencies
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House Calls
Income
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Insurance Coverage
Inter-office Techniques
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Law
Lawyers
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Mr. McClure is director of the Baltimore office of Professional Business Management, Inc. This monthly column is prepared as a complimentary service to the *Maryland State Medical Journal.*

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Montgomery County Auxiliary Raises Funds with Fashions

A bit of Scandinavia's glittering white snow and shimmering ice-like silver found their place in fashions in the annual fund-raising event for the Woman's Auxiliary to the Montgomery County Medical Society, a luncheon-fashion show in the Regency Ballroom of the Shoreham Hotel in Washington, DC, on December 7. A "Winter Wonderland" of fashions was staged by Mrs. Elsie Benjamin, buyer of the designer fashions of La Boutique Saks, with Antoinette Sharkey as commentator. All proceeds will benefit Medical Allied Scholarships and Loan Programs.

The Scandinavian countries were featured and their Ambassadors' wives honored. Mrs. Consuelo Roenne, of Denmark, Madame Gunneng, of Norway, Mrs. Eva deBesche, of Sweden, and Mrs. Eila Munkki, of Finland, were among the guests to see fashions from their countries as well as fashions by other designers. One representative from each embassy modelled her own native costume.

Devron set the musical mood amid Scandinavian holiday decorations. Cherry-Herring miniatures were presented to each guest through the courtesy of Scandinavian Airlines. Frank Harden and Harden Weaver were Masters of Ceremonies.

Mrs. Andrew J. Brennan is president of the Auxiliary and Mrs. Francis C. Mayle was chairman of the luncheon-fashion show. Mrs. James A. Roberts and Mrs. Albert Grollman were in charge of reservations.

Committee chairmen included: Mrs. Solomon Barr, Mrs. Howard Bernstein, Mrs. M. McKendree Boyer, Mrs. Albert Grollman, Mrs. John L Lertora, Mrs. James A. Roberts, Mrs. Charles Saverese, Mrs. Joseph Schanno, Mrs. Robert Smith, Mrs. George R. Spence, Mrs. Robert F. Spicer, Mrs. John B. Umhau, Jr., and Mrs. Albert Zelna.

Mrs. John L. Lertora

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Louis Krause, MD, Chairman
Library and History Committee

Elizabeth Sanford
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Collections Displayed

The Med-Chi Library has displayed collections of recent acquisitions at the semi-annual meeting of the faculty in Ocean City and at regular meetings of Cecil County Medical Society, Prince George's County Medical Society, and Harford County Medical Society. This contact helps to bring Library services closer to the users and acquaints physicians, particularly those new to Maryland, with the possibilities and ease of securing scientific information through the resources of the Faculty's Library.

Materials via MEDIC

Hospitals and other organizations with MEDIC hook-ups may call Med-Chi for library materials needed on a rush basis. The MEDIC receiver is in the administrative office, however, and in order to speak to the Librarian it is necessary to ask the person monitoring MEDIC calls to alert the Library that there is an incoming call. If enough such calls are received, a hand set will be placed in the Library for more efficient handling of requests.

Area Meeting

The District of Columbia-Maryland chapter of the Medical Library Association met in Baltimore on October 21 and 22, 1966, with Welch Medical Library, Johns Hopkins University, as host. Both Health Sciences Library, University of Maryland, and the Medical and Chirurgical Faculty Library assisted with arrangements and registration. At the Friday session of the regional meeting Dr. Carl Douglass, National Library of Medicine, announced that the regional library for this area, as prescribed by the new system of library networks, would include Virginia, West Virginia, District of Columbia and Maryland. Headquarters will be at the National Library of Medicine.

On Saturday, 120 medical librarians and library assistants participated in continuing education courses in "New Reference Tools" and "Human Factors in Library Administration." This was the largest group to register for these courses in any regional meeting to date.

Recent Accessions

Anatomy

Sobotta, Johannes: *Atlas of human anatomy*. Vol 2, translated by Frank H. J. Figge. Atlas of visceral anatomy, digestive, respiratory and urogenital systems. With 122 colored plates and 158 black and white illustrations. 8th Eng ed, Hafner Publishing Co., Inc., NY, 1965.

Bio-medical Engineering

Symposium on bio-mechanics and related bio-engineering topics, Glasgow, 1964, edited by R. M. Kenedi. Biomechanics and related bio-engineering topics; proceedings. 1st ed, Symposium Publications Division, Pergamon Press, NY, 1965.

Burial

Morgan, Ernest: *Manual of simple burial*. 64 pp. How to obtain simplicity, dignity and economy in funeral arrangements through advance planning. The Celo Press, Burnsville, NC, 1966.

Cancer

Everson, Tilden C.: *Spontaneous regression of cancer*. A study and abstract of reports in the world medical

literature and of personal communications concerning spontaneous regression of malignant disease. Saunders, Philadelphia, 1966.

Collagen Diseases

Dubois, Edmund L.: *Lupus erythematosus.* A review of the current status of discord and systemic erythematosus and their variants. 479 pp. The Blakiston Division, McGraw-Hill Book Company, NY, 1966.

Drugs

Council on Drugs, American Medical Association: *New drugs,* AMA, Chicago, 1966.

Epilepsy

Livingston, Samuel, assisted by Pruce, Irving M.: *Drug therapy for epilepsy.* Anti-convulsant drugs and usage, metabolism, untoward reactions (prevention, detection and management). 234 pp. Charles Thomas Publisher, Springfield, Ill, 1966.

Eyes

Becker, B.: *Diagnosis and therapy of the glaucomas,* 2nd ed, Mosby Co., St. Louis, 1965.

Symposium on surgery of the ocular adnexa, New Orleans, 1965. Transactions of the New Orleans Academy of Ophthalmology. Contributors: Arthur Genard DeVoe et al. Mosby Co., St. Louis, 1966.

Cogan, David Glendenning: *Neurology of the visual system.* C. C. Thomas, Springfield, Ill, 1966.

Holland, Harry C.: *The spiral after-effect,* Pergamon Press, NY, 1965.

General Medicine

Journal of the American Medical Association: *Selected questions and answers.* From 1965 issues, 416 pp. AMA, Chicago, 1966.

Health

Clark, Randolph: *The book of health.* A medical encyclopedia for everyone. 888 pp, Van Nostrand, Princeton, NJ, 1962.

Heart Diseases

Friedberg, Charles Kaye: *Diseases of the heart,* 3rd ed, W. B. Saunders Co., Philadelphia, 1966.

Sirak, Howard D.: *Operable heart disease, pathophysiology, diagnosis and treatment.* Mosby Co., St. Louis, 1966.

Hospitals

Rosenfeld, E. D. Associates, Inc.: *Survey and report of hospital facility and service needs of the State of Maryland.* 495 pp, NY, June, 1966.

Infants (New-born)

Abramson, Harold, ed. *Resuscitation of the newborn infant and related emergency procedures.* Principles and practice. 2nd ed, Mosby Co., St. Louis, 1966.

Internal Medicine

Campbell, Meredith F.: *Urology.* Edited by Meredith F. Campbell, 3 v, 2nd ed, W. B. Saunders Co., Philadelphia, 1964.

Stanbury, John: *The metabolic basis of inherited disease,* 2nd ed, 1434 pp, McGraw-Hill Book Co., NY, 1966.

(*continued*)

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All scientific exhibits accepted for showing at the 1967 Annual Meeting will be eligible for judging. As space in the exhibit hall is limited, applications should be sent promptly. Physicians interested should contact the chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore, Maryland 21201.

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The Nervous System

Ochs, Sidney: *Elements of neurophysiology.* J. Wiley, NY, 1965.

Davis, Loyal Edward: *Principles of neurological surgery.* Saunders, Philadelphia, 1963.

Obstetrics

McLennan, Charles E.: *Synopsis of obstetrics,* 7th ed, C. V. Mosby Co., St. Louis, 1966.

Physicians

Gross, Martin: *The doctors.* 650 pp, Random House, NY, 1966.

Sex

Masters, William H.: *Human sexual response* 1st ed, 366 pp, Little Brown & Co., Boston, 1966.

Reinhardt, James Melvin: *Sex perversions and sex crimes.* Thomas, Springfield, Ill, 1957.

Ellis, Albert, 1913: *The psychology of sex offenders.* By Albert Ellis and Ralph Brancale with the collaboration of Ruth R. Doorbar, Thomas, Springfield, Ill, 1956.

DeRuir, Joseph Paul: *The sexual criminal.* A psychoanalytic study. 2nd ed, Thomas, Springfield, Ill, 1965.

U.S. Department of Public Health Service

U.S. Communicable Disease Center, Atlanta: *Communicable disease center training program.* 131 pp. Communicable Disease Center Training Branch, Atlanta, 1966.

U.S. Statistics

U.S. Bureau of the Census: *Statistical Abstract of the United States,* 66th ed, Cities supplement. Covers period 1944-45.

Book Reviews

COMPREHENSIVE APPROACH TO THERAPY OF PAIN, by A. Lewis Kolodny, MD, and Patrick T. McLoughlin, MD. Charles C. Thomas Publisher, Springfield, Ill, 1966, 144 pp. $6.50.

This book should prove of value to any physician called upon to treat pain of any type or degree, but its greatest use will be for those who must treat chronic pain. Emphasis is placed on the fact that the psyche as well as the soma must be treated.

The book opens with "The Historical Aspects of Pain Therapy," followed by a brief outline of the anatomical pathways of pain.

There is a very interesting chapter on the "Development of an Analgesic Drug" in which is discussed the production of new analgesic agents by manipulation of known analgetics and routine screening of newly synthesized chemicals to detect analgesic characteristics. The many steps involved before the agent can be safely used are described.

Following this is a discussion of drug addiction and the many problems involved in treating it.

Several chapters are devoted to drugs: non-narcotic analgesic agents, narcotic analgesic drugs, and analgesic adjuncts. A description of each drug gives both the generic and the trade name, along with mode of action, dosage and side effects.

In one valuable chapter, "Misuse of Analgesic Agents," the authors caution against the too frequent routine use of these drugs with a complete disregard for individual patient variability.

The reader is advised to consider "learning well the pharmacology of a few agents and prescribing these whenever possible," and completely studying all available data concerning new drugs before using them.

This book is well worth reading.

Frank J. Brady, MD

PRIMER ON PREMATURITY AND HIGH-RISK PREGNANCY, by S. Borham Babson, MD, and Ralph C. Benson, MD. The C. V. Mosby Co., St. Louis, 1966, 170 pp. $10.50.

From the preface one learns that this book is designed for the "busy practitioner, house officer, and nurse . . . who care(s) for the high-risk pregnant mother and premature infant. . . ., (but is) at a loss for concise and easily available information regarding these patients."

Prematurity and low birth weight are first defined and their epidemiology considered. The conditions commonly associated with prematurity are then discussed in some detail: rubella, syphilis, multiple pregnancy, placenta praevia, incompetent cervix, thyroid disease, to name a few.

Considered separately are obstetric situations in which delivery is sought as treatment despite lack of fetal maturity: premature ruptured membranes, toxemia abruptio placenta, iso-immunization problems, and diabetes. The hazards of elective induction of labor and scheduled repeat sections are pointed out.

The second half of the book is primarily devoted to the care of this high-risk infant, if delivery is unavoidable. Methods of resuscitation and care of the infant at birth are outlined. Detailed instructions on nursery management follow, with special consideration of infections in the premature. The many and varied anomalies and physiologic handicaps of the premature are surveyed. Some general statements of their long term prognosis conclude the book.

From the obstetric point of view, prematurity is so commonly associated with almost every pathologic situation, that to be completely comprehensive the treatise would have grown to the size of a standard obstetric text. For this reason, the authors are selective, but they have given most consideration to the common entities.

In most specialties there is a fund of knowledge that is written and another that is verbally transmitted, usually in the resident-attending relationship. It is rare to see such 'oral tradition' spelled out in such detail as in this book. The authors have been careful to give majority opinions in this oral tradition, with only a few exceptions.

The authors have achieved their primary goal of providing a reasonable survey of prematurity and its management. This book will probably find its greatest audience among those physicians working in communities without full specialty coverage, where the care of such infants necessarily falls to the less experienced.

The chapters on nursery management should be of help to all nursing staff, regardless of the size of the unit.

James P. Durkan, MD

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Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.
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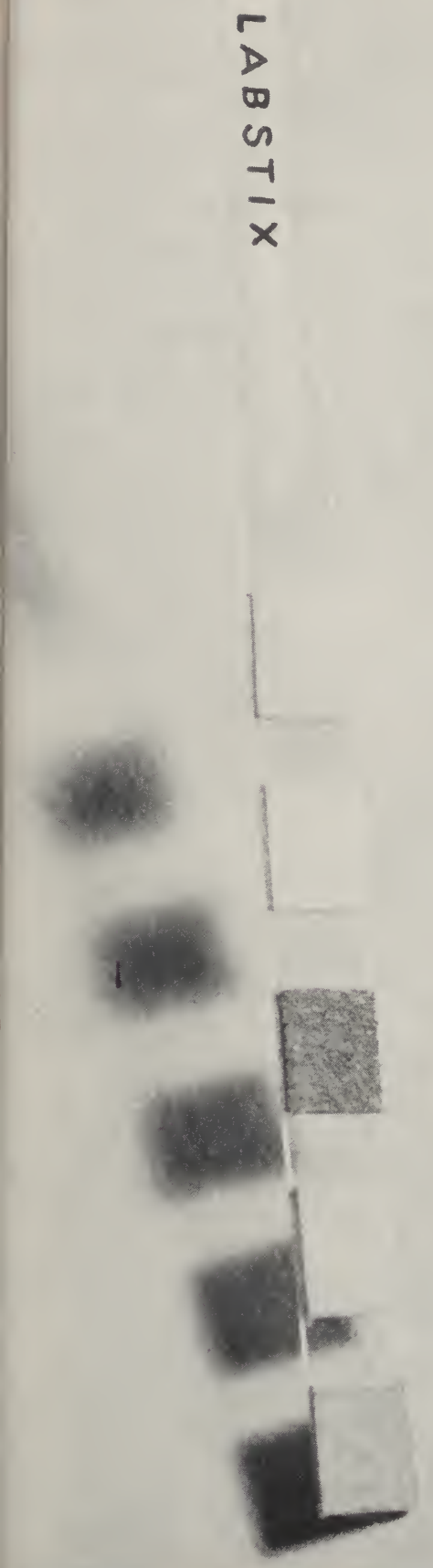
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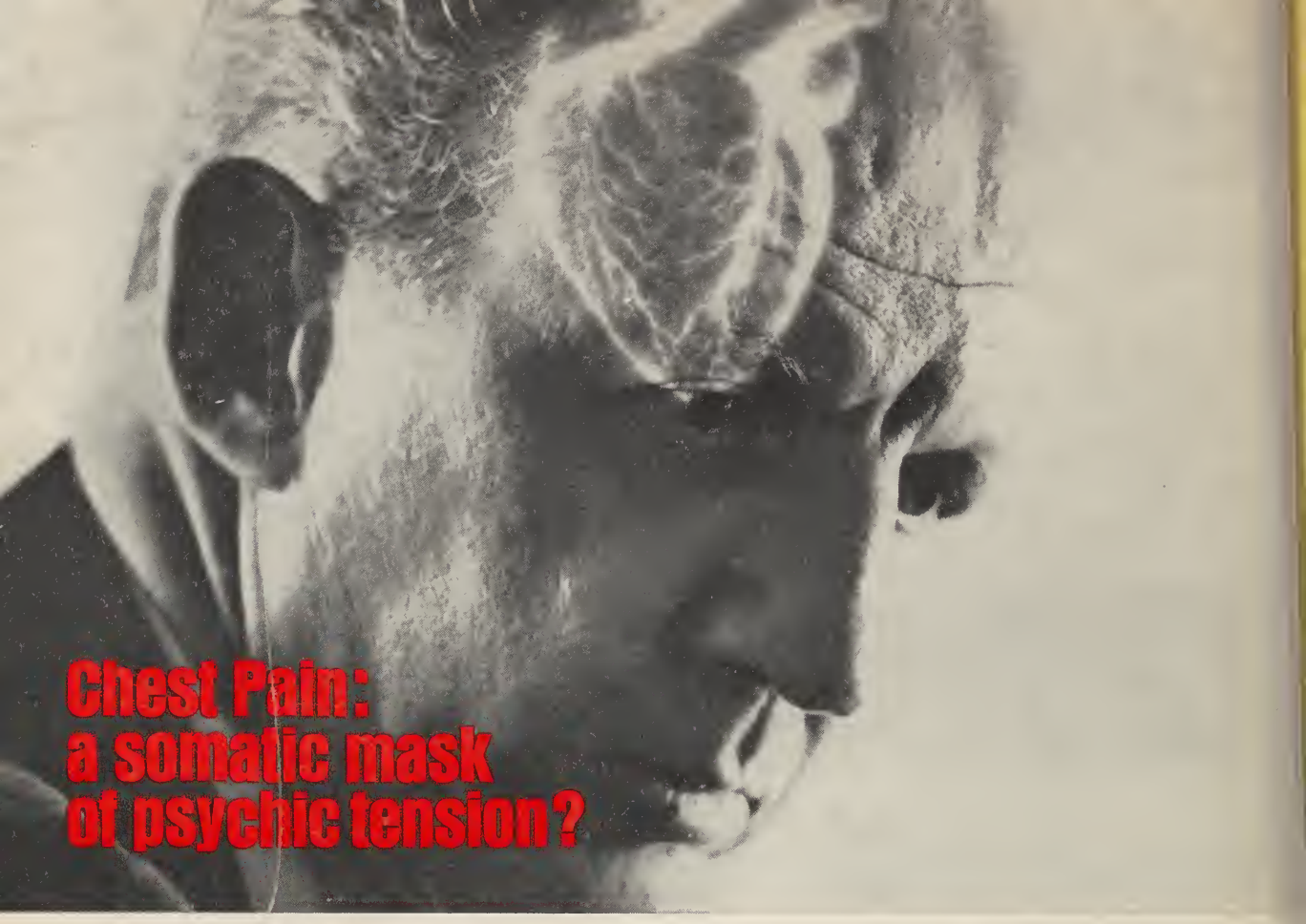
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